

Mississippi EMS

The Law, Rules and Regulations



**Division of EMS
Mississippi State Department of Health
P.O. Box 1700
Jackson, Mississippi 39215-1700**

Equal Opportunity in Employment/Service

***As Proposed to the State Board of Health 4/9/2003**

PROPOSED

Section 1



PROPOSED

Ambulance Service Licensure

Ambulance Service Licensure

Section 1

1.1 License, Permit

The Law §41-59-9; §41-59-11; §41-59-13.

The Division of Emergency Medical Services (DEMS) licenses ambulance services by location and issues permits for each vehicle operated at the location licensed. Individual problems regarding licensure that arise are dealt with by the DEMS. If locations are used to intermittently station ambulance employees and vehicles, and do not serve as points of contact for public business or for deployment control/dispatch centers, licenses for those locations are not required. Ambulance service areas that extend through multiple and/or adjacent counties require an ambulance service license for each county within that area. In these instances, licensure is required though there may not be a fixed identifiable location in each county. DEMS may, at its discretion, allow for exceptions, i.e. when an ambulance service from a single control point provides coverage for only portions of counties that are adjacent, only one license is required.

- 1.1.1. A provider of ambulance service can be licensed by the Division of Emergency Medical Services as an ambulance service by request and by signing a completed application for service license (EMS Form 1). An inspection of premises must be made. A member of the DEMS staff will complete the EMS Form 1 due to the coding requirements of the form.
- 1.1.2. If it is determined that the provider meets all requirements, the DEMS staff member has the authority to grant a license at the time of inspection. The owner copy of EMS Form 1 shall serve as proof of service license until permanent document is received by owner. The license is valid for one (1) year from date of issuance. Any change of service ownership constitutes issuance of a new license and permit(s).
- 1.1.3. Applicants for ambulance service license must provide a roster of all employees including **Medical First Responders**, EMTs, EMS-Ds, dispatchers, RNs, and others if appropriate. This list must include state-issued certification and/or license numbers where applicable.
- 1.1.4. Applicant must submit one copy of the plan of medical control at least 30 days prior to service start date. The plan must include the patient destination criteria and treatment protocols for the trauma patient as delineated by the State Trauma Plan. Plan must include the names of all off-line and on-line medical directors accompanied by credentials, proof of Mississippi physician licensure and controlled substances registration number. In addition, controlled substances registration number and DEA required controlled substances registration certificate for non-hospital based paramedic services for the off-line medical director. Only the lead on-line medical director or each medical control hospital need be listed. Additionally the primary resource hospital and

associate receiving hospital(s); description of methods of medical control; quality assurance and skill maintenance process must be included (See **Appendix 1 Section 4-Medical Direction**).

NOTE: Revisions in the medical control plan must be submitted prior to implementation. At a minimum, medical control plans shall be resubmitted to DEMS every three (3) years.

- 1.1.5. Applicant must provide a letter signed by the **off-line** medical director stating he/she approves the ambulance provider's protocols and understands his/her responsibilities as stated in **Appendix 1 Section 4 - Medical Direction** of the Mississippi EMS Law, Rules and Regulations. This statement may be on forms provided by DEMS.
- 1.1.6. Applicant must provide evidence of 24-hour continuous service capabilities including back-up. Should also include staffing pattern and affiliations with non-transporting ALS services where applicable.
- 1.1.7. Applicant must provide a description of its communications capabilities, however - minimally - the system must be capable of communicating with the primary resource hospital throughout its immediate area of response.*
- 1.1.8 ***911 is the universal emergency phone number for public access of Emergency Medical Services in the State. Ambulance service providers shall only advertise 911 as their emergency number. Exception: If a municipality or county has not implemented 911, then for that area, a seven-digit phone number may be used. This exception must have prior approval in writing by the DEMS. It is the intent of this regulation that 911, the universal access number for EMS, be the only emergency number advertised to the public. Any advertisement of a non-emergency phone number must include a prominent display of 911 or other DEMS approved emergency phone number.***

*(Bio-medical telemetry is not required if so documented in the communications plan by the medical director).

NOTE: Ambulance services shall submit Mississippi Uniform Accident Reports involving EMS permitted vehicles with license renewals.

1.2 Inspections

•The Law §41-59-15.

- 1.2.1. "It shall be a regulation of the State Board of Health that during the inspection of emergency and/or invalid vehicles the owner, or an employee of the particular ambulance company, be present during the inspection and where necessary be subject to demonstrating certain equipment items."

•Policy for Administration

- 1.2.2. Inspections to insure compliance with the law will be made not less than two (2) times each year licensed and in most cases four (4) times.

1.3 License Suspension, Revocation, Renewal

•The Law §41-59-17.

- 1.3.1. No employer shall employ or permit any employee to perform any services for which a license/certificate or other authorization (as required by this act or by the rules and regulations promulgated pursuant to this act) unless and until the person possesses all the licenses, certificates or authorization that are so required.
- 1.3.2. No owner of a publicly or privately owned ambulance service shall permit the operation of the ambulance in emergency service unless the attendant on duty therein possesses evidence of that specialized training as is necessary to insure that the attendant or operator is competent to care for the sick or injured persons, according to their degree of illness or injury, who may be transported by the ambulance, as set forth in the emergency medical training and education standards for emergency medical service personnel established by the State Department of Health, Division of EMS.
- 1.3.3. The owner/manager or medical director of each publicly or privately owned ambulance service shall immediately inform the State Department of Health, Division of EMS of the termination or other disciplinary action taken against an employee because of the misuse of alcohol, narcotics or other controlled substances.
- 1.3.4. Other common grounds for suspension or revocation are for example, but not limited to:
- 1.3.4.1. Lack of State certified EMT attending patient.
 - 1.3.4.2. Lack of driver with valid driver's license and state EMS driver certification.
 - 1.3.4.3. Lack of proper equipment required by law.
 - 1.3.4.4. Not adhering to sanitation of vehicle and equipment requirements.
 - 1.3.4.5. Failure to adhere to record keeping or reporting requirements required by DEMS.
 - 1.3.4.6. Failure to maintain proper insurance required by law.
- 1.3.5. A license can be temporarily suspended or revoked by any staff member of the DEMS at time of violation, and will be followed up by a letter of temporary suspension or revocation. This letter will be certified, return receipt requested. This action may be taken with just cause in an effort to protect the public. Within five days from the time of temporary suspension or revocation, DEMS may extend the suspension, reinstate or revoke the license.

•Other Information

The right to appeal process is discussed in section 41-59-49.

1.4 Ownership, Changes

•The Law §41-59-19.

•Policy and Administration

- 1.4.1. Any change of ownership or location voids original license and permit(s). Such changes constitute issuance of new service license and permit(s). (Application process must be initiated and completed by the new owner).

1.5 Conformance with Local Laws

•The Law §41-59-21.

1.6 Permits, All Vehicles

•The Law §41-59-23.

•Policy for Administration

- 1.6.1. Permits are issued by the DEMS to a licensed ambulance service after an inspection of the vehicles and equipment has been completed and a determination made by DEMS that all requirements have been met.
- 1.6.2. Permits issued shall expire concurrently with the service license.
- 1.6.3. An EMS Form 2 must be filled out by DEMS and signed by the owner or his designated representative.
- 1.6.4. DEMS may give permission for vehicle operation at the time of inspection if judgement is made that the vehicle meets all requirements. The owner copy of EMS Form 2 shall serve as proof of permit until permanent document is received by owner.
- 1.6.5. All permits for vehicles are issued by licensed location. If, at any time, a vehicle is permanently moved to a new location a new inspection must be made and a new permit issued in accordance with the service license for the new location.
- 1.6.6. Common grounds for suspension or revocation of vehicle permit are, for example:
- 1.6.6.1. Improper or lack of essential required equipment, design and construction standards
 - 1.6.6.2. Sanitary requirements not maintained
 - 1.6.6.3. Lack of properly certified personnel in rear of vehicle when patient is present or lack of properly qualified driver
 - 1.6.6.4. Failure to maintain insurance as required
 - 1.6.6.5. Change in location of vehicle
 - 1.6.6.6. Failure to carry DEMS issued permit card on vehicle
- 1.6.7. Common grounds for issuance of temporary permit (limited to 90 days) are for example:
- 1.6.7.1. Minor equipment items missing, but to be replaced within a reasonable time period.
 - 1.6.7.2. Permitted vehicle is under repair and a replacement vehicle, meeting standards, is needed on a temporary basis.

1.7 Vehicle Standards

•The Law §41-59-25.

•Rules and Regulations

1.7.1. Standards for the design, construction and equipment of ambulance vehicles.

All new ambulance vehicles, before being issued an original ambulance permit as authorized by Mississippi Code 41-59-23, shall conform to current Federal Specification 'Star-of-Life Ambulance' as published by the General Services Administration, Specification Section. Ambulances that were constructed prior to the implementation of the current Federal Specifications shall conform to the applicable Federal Specifications that were in effect at the time of original construction. The following are exceptions and additions:

1.7.1.1. Height

Overall height of the ambulance at curb weight shall not exceed 110 inches, excluding roof-mounted light bars and communications accessories.

1.7.1.2. Color Paint and Finish

The exterior color of the ambulance shall be basically white in combination with a solid uninterrupted orange stripe and blue lettering and emblems. The band (stripe) of orange not less than 6 inches wide, nor more than 14 inches wide shall encircle the entire ambulance body configuration at the belt line below the lowest edge of cab windows but may exclude the front of the hood panel. (The orange stripe may be edged/pin striped in black or blue.) This solid (single) band, when viewed horizontally, shall appear as a stripe near parallel to the road. When vinyl orange stripes are used rather than paint, it is acceptable to interrupt the strip at the corners of the vehicle to allow the vinyl to mold appropriately.

1.7.1.2.1. Additional lettering and markings are allowed in, above and below the stripe, however, these markings shall not completely traverse or interrupt the stripe at any point.

1.7.1.2.2. The name of the ambulance company shall be printed in minimum 4 inch high letters of highly visible contrasting color on each side of the ambulance or on the doors.

1.7.1.2.3. Letters, words, phrases, or designs suggesting special services, i.e., advanced life support, etc., shall be allowed provided such specialty services are in fact available in the vehicle at all times when in operation.

1.7.1.2.4. If the construction and design of an ambulance prohibits the placement of the ambulance (reverse) decal on the front hood, it shall be an acceptable exemption. DEMS shall have the authority to grant exceptions to requirements for color, paint, finish and essential equipment for certain transport capable vehicles that are used exclusively for special situations, i.e. neonatal transport.

1.7.1.2.5. The DEMS shall have the authority to grant exceptions to requirements for color, paint, finish, and essential equipment for certain transport capable vehicles that are used exclusively for special situations, i.e. neonatal transport, etc. If the special needs of the patient-types for these special use vehicles are not met by the standards required in these regulations, the vehicles shall be exempt from said regulations and instead should be equipped with essential equipment needed to manage the individual patient types.

- 1.7.1.3. **Suction aspirator system**
Shall be electrically powered. Shall provide a free airflow of at least 30 lpm at the distal end of the connected patient hose. It shall achieve a vacuum of at least 300 mmHG (11.8 inches) within 4 seconds after the suction tube is clamped closed.
- 1.7.1.4. **Portable suction aspirator**
The unit will be self-contained, portable, battery operated, suction apparatus with wide-bore tubing. Gas powered or manual, portable suction aspirators may be substituted for battery operated suction units provided that they meet same operational standards.
- 1.7.1.5. **Two-way (mobile) radio equipment**
One two-way radio (155.340 MHZ) or acceptable alternative that is compatible or interoperable for communication on radio frequency 155.340.
- 1.7.1.6. **Standard mandatory miscellaneous equipment**
Unless otherwise precluded elsewhere in this specification, each ambulance shall be equipped with, but not limited to, the following:
- 1.7.1.6.1. Fire extinguisher: one, ABC dry chemical, multi-purpose (Halon, CO₂) minimum 5 pound unit in a quick-release bracket mounted in the patient compartment.
- 1.7.1.7. **Medical, surgical, and bio-medical equipment**
When specified (see 6.2), the ambulance shall be equipped with, but not limited to, the following:
- 1.7.1.7.1. One stretcher for primary patient as specified in current Federal Specifications for ambulances, dimensions as per KKK-A-1822.
- 1.7.1.7.2. 3 strap type restraining devices (chest, hip, knee) attached to stretcher. Straps shall not be less than two inches wide, nylon, and consist of two-piece assembly with quick release buckles.
- 1.7.1.7.3. Portable and fixed oxygen equipment with variable flow regulator capable of delivering 15 lpm in calibrated increments. Cylinder must contain 300 psi of medical grade O₂ at a minimum.
- 1.7.1.7.4. Three oxygen masks, adult. (Non-rebreathing face mask)
- 1.7.1.7.5. One oxygen mask, child.
- 1.7.1.7.6. One oxygen mask, infant.
- 1.7.1.7.7. Three oxygen bi-pronged nasal cannulas.
- 1.7.1.7.8. One mouth-to-mask artificial ventilation device with supplemental oxygen inlet port with one-way valve, i.e., "pocket mask", etc.
- 1.7.1.7.9. One bag-valve-mask device, adult, without pop-off valve, with oxygen reservoir capable of delivering 80-100 percent oxygen.
- 1.7.1.7.10. One bag-valve-mask device, pediatric, without pop-off valve, with oxygen reservoir capable of delivering 80-100 percent oxygen.
- 1.7.1.7.11. One bag-valve-mask device, infant, without pop-off valve, with oxygen reservoir capable of delivering 80-100 percent oxygen.
- 1.7.1.7.12. Two adult oropharyngeal airways.
- 1.7.1.7.13. Two child oropharyngeal airways.
- 1.7.1.7.14. Two infant oropharyngeal airways.
- 1.7.1.7.15. One adult nasopharyngeal airway 28-36 fr. or 7.0-9.0 mm.
- 1.7.1.7.16. One child nasopharyngeal airway 20-26 fr. or 5.0-6.0 mm.
- 1.7.1.7.17. One bite stick.
- 1.7.1.7.18. Six large, sterile, individually wrapped, trauma dressings (minimal six 8" x 10").

- 1.7.1.7.19. Twelve sterile, individually wrapped (or in two's), dressings 4" x 4".
- 1.7.1.7.20. Three soft roller bandages, 4" or larger.
- 1.7.1.7.21. Three triangular bandages or commercial arm slings.
- 1.7.1.7.22. Two rolls adhesive tape, 2" or larger.
- 1.7.1.7.23. One pair of shears for bandages.
- 1.7.1.7.24. One sterile, Vaseline gauze, 3" x 8" or larger.
- 1.7.1.7.25. One rigid cervical collar, large.
- 1.7.1.7.26. One rigid cervical collar, medium.
- 1.7.1.7.27. One rigid cervical collar, small.

NOTE: Two adjustable, rigid collars may be substituted for items Y, Z, and AA.

- 1.7.1.7.28. One lower extremity traction splint, limb-support slings, padded ankle hitch, padded pelvic support, traction strap.
- 1.7.1.7.29. Assorted sized extremity immobilization devices which will provide for immobilization of joint above and joint below fracture and rigid support and be appropriate material (cardboard, metal, pneumatic, wood, plastic, etc.).
- 1.7.1.7.30. One short spine board with accessories or commercial equivalent (KED, Kansas Board, etc.).
- 1.7.1.7.31. Two long spine boards with accessories.
- 1.7.1.7.32. One folding stretcher as specified in current Federal Specifications for Ambulances, style 3 (folding legs optional) or a combination stretcher chair designed to permit a patient to be carried on stairways and/or through narrow areas.
- 1.7.1.7.33. Two blanket rolls or commercial equivalent.
- 1.7.1.7.34. Two sterile or clean burn sheets (packaged and stored separately from other linens).
- 1.7.1.7.35. Six clean sheets (2 on cot and 4 spare).
- 1.7.1.7.36. Three pillow cases (1 on pillow and 2 spare).
- 1.7.1.7.37. Two blankets.
- 1.7.1.7.38. One sterile OB kit.
- 1.7.1.7.39. One adult blood pressure cuff with aneroid gauge.
- 1.7.1.7.40. One pediatric blood pressure cuff with aneroid gauge.
- 1.7.1.7.41. One stethoscope.
- 1.7.1.7.42. One roll aluminum foil or silver swaddler (enough to cover newborn).
- 1.7.1.7.43. Infant blood pressure cuff with aneroid gauge.
- 1.7.1.7.44. One penlight/flashlight.
- 1.7.1.7.45. Two liters sterile water for irrigation.

NOTE: Sterile saline may be substituted. Unbroken seal required.

- 1.7.1.7.46. One container of water for purging fixed suction device.
- 1.7.1.7.47. One container of water for purging portable suction devices.
- 1.7.1.7.48. One 15g. glucose or other commercial derivative for oral administration.
- 1.7.1.7.49. 50g. activated charcoal.
- 1.7.1.7.50. Infectious disease precaution materials
- 1.7.1.7.50.1. 1. disposable latex gloves (6 pair)

- 1.7.1.7.50.2. 2. disposable goggles and masks (2 pair) or face shields (4)
- 1.7.1.7.50.3. 3. impervious gown or apron (2)
- 1.7.1.7.50.4. 4. disinfectant for hands and equipment
- 1.7.1.7.50.5. 5. sharps container (see OSHA regulations in Appendix 8)
- 1.7.1.7.50.6. 6. two leakproof plastic bags for contaminated waste.
- 1.7.1.7.51. Two disposable rigid non-metallic suction tips with wide-bore inside diameter of at least 18 fr.
- 1.7.1.7.52. Two of each size sterile disposable suction catheters
- 1.7.1.7.52.1. (2 each - 5-6 fr.)
- 1.7.1.7.52.2. (2 each - 8-10 fr.)
- 1.7.1.7.52.3. (2 each - 14-18 fr.)
- 1.7.1.7.53. One bedpan, one urinal, and one emesis basin or commercial equipment.
- 1.7.1.7.54. Automated external defibrillator (AED)

NOTE: In addition to the previously listed BLS regulations, the following additional ALS requirements must be met:

1. Only vehicles meeting current state regulations for emergency ambulance classifications may be approved and permitted as ALS vehicles.
2. All ALS vehicles shall conform to the advanced equipment guidelines established by the American College of Surgeons, Committee on Trauma, and as may be modified by the State Board of Health.
3. If not stored on the ambulance, the equipment and supplies required for advanced life support at the EMT-Intermediate or EMT-Paramedic level, must be stored and packaged in such a manner that they can be delivered to the scene on or before the response of the ALS personnel. This may be accomplished by rapid response units or other non-ambulance emergency vehicle.

NOTE: ALS services are required to have ALS equipment commensurate with the ALS staffing plan submitted as part of the application for service licensure.

1.7.1.8. **EMT- Intermediate**

For the EMT-I all the equipment for the EMT-B as previously listed plus the following equipment and supplies:

- 1.7.1.8.1. **Intravenous administration equipment** (fluid should be in bags, not bottles), ringers lactate and/or normal saline (4000 ML minimum), dextrose (5% in water 250 cc bags, 2 each minimum), intravenous administration set (3 each), intravenous catheter with needle (1"-3" in length; 22, 20, 18, 16, 14 gauge, 6 each minimum), venous tourniquet, antiseptic solution, IV pole or roof hook.
- 1.7.1.8.2. **Airway**
Esophageal obturator airway or esophageal gastric tube airway with mask, 35cc syringe, stethoscope. (NOTE: May utilize either EOA, EGTA, PTL, or combitube.)
- 1.7.1.8.3. **End-tidal CO2 Detectors (may be made onto bag valve mask assemblies or separate)**

- 1.7.1.8.4. **Cardiac**
Manual monitor defibrillator (with tape write-out), Defibrillation pads or jell, quick-look paddles, EKG leads, Chest attachment pads (telemetry radio capability optional). Automated or semi-automated defibrillator (AED) which: a) is capable of cardiac rhythm analysis; b) will charge and deliver a shock after electrically detecting the presence of a cardiac dysrhythmia or is a rhythm and display a message advising the operator to press a “shock” control to deliver the shock; c) must be capable of retaining and reproducing a post event summary (at a minimum the post event summary should include time, joules delivered and ECG).
- 1.7.1.9 **EMT-Paramedic**
All the equipment and supplies listed above plus the following additional equipment and supplies:
- 1.7.1.9.1. **Airway**
Endotracheal tube (adult, child, and infant sizes), 10cc syringes, stylets, laryngoscope handle, blades (adult, child, and infant sizes, curved and/or straight), end-tidal CO2 detector (adult and pediatric).
- 1.7.1.9.2. **Manual cardiac monitor defibrillator** with tape write-out and synchronization capabilities.
- 1.7.1.9.3. **Drugs** (pre-load when available)
Drugs used on EMT-P units should be compatible with the minimum standards set by the Department of Transportation. The following drugs are required:

50% Dextrose	Atropine
Bronchodilator	Calcium Chloride
Diphenhydramine	Dopamine
Epinephrine	Furosemide
Lidocaine	Naloxone
Nitroglycerine (spray or tablets)	Sodium Bicarbonate
Syrup of Ipecac	

The following drugs are optional:

Adenosine (Adenocard)	Antiemetics
Aspirin	Bretylium.
Cetacaine	Demerol
Dexamethasone	Diazepam
Dobutamine	Flumazenil (Mazicon)

Glucagon	Haldol
Isorpoteranol	Levophed
Lorazepam (Ativan)	Magnesium sulfate
Mannitol	Morphine
Nitrous oxide	Oxytocin
Procainamide	Pralidoxime (2-PAM)
Thiamine	Verapamil

*Any drug other than those specified here may be carried if previously approved and included in the medical control plan.

1.7.1.10. **Sanitation regulations**

The following shall apply regarding sanitation standards for all types of ambulance vehicles:

- 1.7.1.10.1. A. The interior of the ambulance and the equipment within the ambulance shall be sanitary and maintained in good working order at all times.
- 1.7.1.10.2. B. Equipment shall be made of smooth and easily cleanable construction.
- 1.7.1.10.3. C. Freshly laundered linen or disposable linen shall be used on cots and pillows and linens shall be changed after each patient is transported.
- 1.7.1.10.4. D. Clean linen storage shall be provided on each ambulance.
- 1.7.1.10.5. E. Closed compartments shall be provided within the ambulance for medical supplies.
- 1.7.1.10.6. F. Pillows and mattresses shall be kept clean and in good repair.
- 1.7.1.10.7. G. Closed containers shall be provided for soiled supplies.
- 1.7.1.10.8. H. Exterior and interior surfaces of ambulance shall be cleaned routinely.
- 1.7.1.10.9. I. Blankets and hand towels used in any ambulance shall be clean.
- 1.7.1.10.10. J. Implements inserted into the patient's nose or mouth shall be single service, wrapped and properly stored and handled. When multi-use items are used, the local health care facilities should be consulted for instructions in sanitation and handling of such items.
- 1.7.1.10.11. K. When an ambulance has been utilized to transport a patient known to the operator to have a communicable disease, the vehicle shall be placed "out of service" until a thorough cleansing is conducted.
- 1.7.1.10.12. L. All storage spaces used for storage of linens, equipment, medical supplies and other supplies at base stations shall be kept clean and free from unnecessary articles. The contents shall be arranged so as to permit thorough cleaning.
- 1.7.1.10.13. M. In addition, current CDC and OSHA requirements apply.

•Other Information

1.7.2. **Narcotics**

Certified ALS personnel (paramedics and RNs) functioning under approved medical control jurisdiction may be issued approved controlled substances for pre-hospital use

upon the discretion of the off-line medical director. For ALS services that are not hospital-based, the Drug Enforcement Administration (DEA) requires the off-line medical director to secure a separate CONTROLLED SUBSTANCES REGISTRATION CERTIFICATE to store, issue and prescribe controlled substances to ALS personnel. This CERTIFICATE should list the medical director as a "practitioner" at the physical address of the ambulance service where the drugs are stored. The off-line medical director will determine who may issue and administer the controlled substances and who will have access to storage of these narcotics.

- 1.7.2.1. Controlled substances must be secured in accordance with applicable state and federal regulations. The paramedic's narcotics should be secured in a designated location when he is not on duty and actively functioning under the service's medical control. When on duty, each paramedic should keep his controlled drugs in his immediate possession or securely locked in the vehicle at all times.
- 1.7.2.2. Whenever an order is received from medical control for administration of a narcotic, the paramedic must keep track of the vial/ampule being utilized. If the full amount of the narcotic was not administered, the remainder must be wasted in the presence of a witness and the witness must sign the patient report documenting same. The witness should preferably be a licensed health care provider who is authorized to administer narcotics themselves.
- 1.7.2.3. Narcotics should be replaced and logged within 24 hours of administration. Narcotics logs should be maintained by the ALS service. Paramedics should individually document the following minimum information in the narcotics log:
 - Date of administration
 - Time of administration
 - Amount administered
 - Amount wasted
 - Witness to wasted amount
 - Patient's name
 - Call number
 - Ordering physician
- 1.7.2.4. Any paramedic/RN who is separated from the ALS service's medical control authority shall surrender his narcotics upon demand or be subject to prosecution under applicable statutes.

1.7.3. **Prescription Items**

All ambulance services licensed by the DEMS are required to have approved medical directors. BLS ambulance services are required to have designated an off-line medical director only. These physician directors are necessary to allow the services to store and administer certain prescription items as required in the Rules and Regulations of the DEMS.

1.7.4. **Storage of Prescription Items**

Ambulance services and personnel should not store or carry prescription drugs or items which they are prohibited from using. Personnel who are allowed to administer prescription drugs or use prescription items should carry these drugs and/or items only when they are on duty and actively functioning under their ambulance service's medical

control authority.

- 1.7.4.1. Prescription items and drugs should always be stored and carried in secure locations accessible only to authorized personnel. These items and drugs should be stored within temperature ranges as recommended by the manufacturer.

1.8 Special Use EMS Vehicles

•The Law §41-59-3.

•Rules and Regulations

- 1.8.1. Special Use Emergency Medical Services Vehicles (SUEMSV) used on roadways shall be equipped with the following minimum emergency warning devices:
 - 1.8.1.1. A combination electronic siren with integral public address system.
 - 1.8.1.2. Strobe, **light emitting diode (LED)** or quartz halogen incandescent red or combination red/clear emergency lights providing the vehicle with a conspicuous appearance for safety during emergency response. The emergency lights must display highly perceptible and attention-getting signals designed to convey the message "clear the right-of-way."
 - 1.8.1.3. Use of emergency warning devices by SUEMSV is restricted to actual EMS responses as authorized and requested by the licensed ambulance service **or DEMS.**

•Policy for Administration

- 1.8.2. Permits for special use EMS vehicles are issued by DEMS to a licensed ambulance service after an inspection of the vehicles has been completed and a determination made by DEMS that all requirements have been met.
- 1.8.3. Permits issued shall expire concurrently with the service license.
- 1.8.4. All permits for vehicles are issued by licensed location. If, at any time, a vehicle is moved to a new location, a new inspection must be made and a new permit issued in accordance with the service license for the new location.
- 1.8.5. The permit fee is \$100.00 per vehicle.
- 1.8.6. Personnel operating ground SUEMSV must be certified as EMS-D.
- 1.8.7. Each SUEMSV must be insured as per Section 41-59-27, Mississippi Code of 1972, Annotated.

1.9 Required Personnel

•The Law §41-59-29.

•Rules and Regulations

- 1.9.1. Every ALS ambulance, when responding to and transporting patients requiring care beyond the basic life support level, must be occupied by a driver with a valid driver's license and one (1) person who possesses a valid EMT-I or EMT-P state certificate (if service is licensed as Intermediate level), or one (1) person who possesses a valid EMT-P state certificate (if service is licensed as a Paramedic level), or one (1) person who possesses a valid medical/nursing license.
- 1.9.2. In addition, any ambulance service that wishes to provide ALS and employ ALS personnel to function in an ALS role, intermittently or consistently, must be licensed at the ALS level by the State Department of Health, Division of Emergency Medical Services.
- 1.9.3. Anyone driving an ambulance or (invalid) vehicle must possess a valid emergency medical service driver (EMS-D) state certificate in addition to a valid driver's license.

•Other Information

- 1.9.4. Verification of training for personnel functioning in an out-of-hospital Advanced Life Support (ALS) role may be as follows:
 - 1.9.4.1. Current registration as an EMT-I/EMT-P by the National Registry of EMTs.
 - 1.9.4.2. Letter/statement signed by the ambulance service owner/manager which attests to equivalency of training (National Standard Training Curriculum for EMT I/P) for each employee possessing a medical/nursing license.

1.10 Insurance Requirements

•The Law §41-59-27.

1.11 Record Keeping

•The Law §41-59-41.

•Rules and Regulations

- 1.11.1. All licensed ambulance services operating in the State of Mississippi must submit **electronically**, the State of Mississippi Patient Encounter Form and/or information contained on the form via network, **or** direct computer link, **or computer floppy disk** for each ambulance run made and/or for each patient transported.
- 1.11.2. **A completed copy of a Mississippi Patient Encounter Form or Patient Care Report containing the data elements of the Mississippi Patient Encounter Form shall be left with hospital staff for all patients delivered to licensed Hospitals. If in the best interest of the public good, an immediate response to a patient is required of an ambulance delivering a patient to a licensed Hospital, a complete oral report on the patient being delivered will be given to the receiving facility and a completed copy of a Mississippi Patient Encounter Form or Patient Care Report containing the data elements of the Mississippi Patient Encounter Form for that patient shall be delivered in person or by fax to the hospital staff of the licensed Hospital within 24 hours.**

- 1.11.3. All ~~computer disk or~~ **Mississippi Patient Encounter Forms** are due in the DEMS office by the seventh day after the close of the preceding month.
- 1.11.4. All **Mississippi Patient Encounter Forms** or computer disk information returned to an ambulance service for correction must be corrected and returned to the DEMS office within two weeks calculated from the date of their return.
- 1.11.5. Returns to a licensed ambulance service provider greater than 3 times may result in a penalty as outlined under Section 41-59-45, paragraph 3.

•Policy for Administration

1. ~~Sufficient copies of the State of Mississippi Patient Encounter Form are furnished by DEMS for all licensed ambulance services. Each ambulance service will be provided with one year's supply of these report forms.~~

1.12 Invalid Vehicles

•The Law §41-59-39.

•Rules and Regulations

1.12.1. Standards.

- 1.12.1.1. No vehicle used exclusively for invalid transfer is to have any markings, flashing lights, sirens, or other equipment that might indicate it is an Emergency Vehicle. The word "Ambulance" is not to appear on the vehicle.
- 1.12.1.2. The vehicle will have at least two doors leading into the patient compartment; one at the rear for patient loading and one on the curbside so that the patient may be easily removed should the rear door become jammed. All doors should be constructed so that they may be opened from inside or outside.
- 1.12.1.3. Stretcher holders and litter straps will be required for patient safety. Seat belts will be required for occupants of the driver compartment.

1.12.2. Required equipment.

- 1.12.2.1. First aid kit: Commercially available kit containing gauze pads, roller bandages, and adhesive tape acceptable
- 1.12.2.2. 5 pound dry chemical fire extinguisher
- 1.12.2.3. 1 box disposable tissues
- 1.12.2.4. 1 bed pan (fracture type acceptable)
- 1.12.2.5. 1 emesis basin
- 1.12.2.6. 2 towels
- 1.12.2.7. 1 blanket
- 1.12.2.8. 4 sheets
- 1.12.2.9. 2 pillow cases
- 1.12.2.10. 1 wheeled cot meeting or exceeding requirements in Federal Specifications for Ambulances
- 1.12.2.11. 1 wheeled cot retention system as determined by DEMS
- 1.12.2.12. 1 detachable safety retaining strap for wheeled cot

1.12.3. Vehicle Standards

- 1.12.3.1. Patient Compartment:
- 1.12.3.2. 42" high, floor to ceiling
- 1.12.3.3. 48" wide, measured 15" above floor from side to side
- 1.12.3.4. 92" long, measured 15" above floor from divider to rear door

1.12.4. Emblems and markings:

- 1.12.4.1. The name of the company shall be printed on each side of the vehicle or the cab doors of the vehicle.

1.13 License Not Required

- The Law §41-59-43.

1.14 Penalties

- The Law §41-59-45.

1.15 Participation, Options

- The Law §41-59-47.

1.16 Appeal Process

- The Law §41-59-49.

•Other Information

- 1.16.1. The State Board of Health and the Division of EMS shall provide an opportunity for a fair hearing for every licensee of ambulance service who is dissatisfied with administrative decisions made in the denial and/or suspension/revocation of a license.
- 1.16.2. DEMS shall notify the licensee by registered mail, the particular reason for denial or revocation/suspension of the license. Upon written request of the licensee within ten days of the notification, DEMS shall fix a date not less than thirty days from the date of such service at which time the licensee shall be given an opportunity for a prompt and fair hearing before officials of the Mississippi State Department of Health.
- 1.16.3. On the basis of such hearing or upon the fault of the applicant or licensee, the Mississippi State Department of Health shall make a determination specifying the findings of fact in conclusion of the law. A copy of such determination shall be sent by registered mail to the last known address of the licensee or served personally upon the licensee.
- 1.16.4. The decision to suspend, revoke or deny a license shall become final thirty days after it is mailed or served unless the applicant or licensee within such thirty days, appeals the decision to the Chancery Court of the county where the applicant or licensee is domiciled.

1.17 Subscription Services

•The Law §41-59-63.

1.18 Application Process

•The Law §41-59-65.

•Policy for Administration

1.18.1. All subscription permits issued are valid for a **maximum** period of one (1) year. This period is from January 1 through December 31. **Regardless of date of issuance, all subscription permits expire on December 31 of each calendar year.**

1.18.2. The Five Hundred Dollars (\$500.00) permit fee is in addition to the fee for BLS or ALS licensure.

1.19 Program Requirements

•The Law §41-59-67.

•Policy for Administration

1.19.1. Each membership subscription ambulance service provided must forward a copy (copies) of all surety bonds purchased along with an official statement of total subscribers covered. Such information is made part of the application for subscription permit. During the permit period, should bonds be cancelled, voided, or changed in any way, DEMS must be notified by the service provider.

1.19.2. Proof of the establishment of a reserve fund must be provided to DEMS as a prerequisite to DEMS issuance of a subscription permit. Monthly reserve statement's of cash balances must be forwarded to DEMS by either the EMS provider and/or the bank in which the reserve account is established.

1.20 Annual Reports

•The Law §41-59-69.

•Policy for Administration

1.20.1. Each subscription ambulance service must submit its annual report with all information as required in Section 41-59-69 within 45 days after the expiration of the subscription permit period (February 14).

1.20.2. The annual report may be submitted in letter form to DEMS with supporting documentation as is necessary.

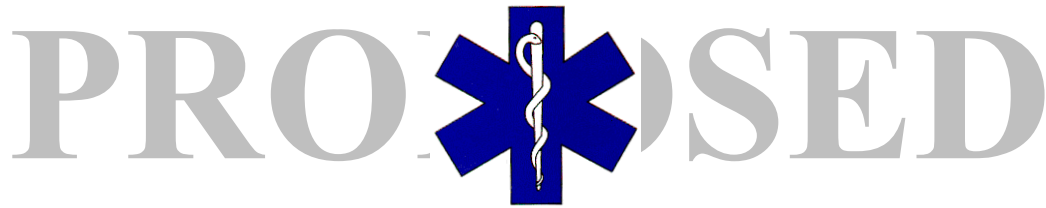
1.20.3. DEMS will suspend all subscription permits of ambulance services failing to file annual reports within the prescribed period.

1.21 Solicitation of Membership

•The Law §41-59-71.

PROPOSED

Section II



Inter-Hospital Transfers

2.1 Transfers

The Law §41-60-13

Rules and Regulations

- 2.1.1. Ambulance personnel cannot transport patients whose medical needs exceed the capabilities of those personnel. Specifically, EMS personnel cannot transport patients with needs or reasonably perceived needs for care which exceed the scope of practice for the ambulance attendant. EMS personnel are restricted to performance of those skills as authorized by the State Department of Health, Division of Emergency Medical Services.
- 2.1.2. Ambulance personnel aiding in the transfer should confirm that the facility to which the patient is to be transferred has been notified and has agreed to accept the patient. They should also inquire whether the patient's condition is stable (no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from the facility) and whether a nurse, physician or other medical personnel should accompany the patient during transfer.
- 2.1.3. If a patient at a hospital has an emergency medical condition which has not been stabilized (as defined herein), the hospital should not request the transfer and the ambulance service should not transfer the patient unless:
 - 2.1.3.1. the patient (or legally responsible person acting on the patient's behalf) request that the transfer be effected;
 - 2.1.3.2. a physician or other qualified medical personnel when a physician is not readily available, has verified that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risk to the individual's medical condition from effecting the transfer; or,
 - 2.1.3.3. the transfer is an appropriate transfer to that facility (see Appendix 6).

Section III



Aero Medical Emergency Medical Services

3.1 Aero Medical Emergency Medical Services

The Law §41-59-9.

Rules and Regulations

3.1.1. Definitions Relative to Aero Medical EMS:

- 3.1.1.1 Advanced Life Support Care (ALSC)** - Means a sophisticated level of pre-hospital and inter-hospital emergency care which includes basic life support functions including cardiopulmonary resuscitation (CPR), plus cardiac defibrillation, telemetered electrocardiography, administration of anti-arrhythmic agents, intravenous therapy, administration of specific medications, drugs and solutions, use of adjunctive ventilation devices, trauma care and other authorized techniques and procedures. This level of care (quantity and type of staff member(s), equipment and procedures) is consistent with a patient in a pre-hospital emergency or non-emergency incident. In addition, this level of care (quantity and type of staff member(s), equipment and procedures) is consistent with a patient in a inter-hospital incident who is in a non-acute situation and is being cared for in an environment where monitoring of cardiac rhythm, neurological status, and/or continuous infusions of anti-arrhythmic and/or vasopressors, are part of the patient's care needs.
- 3.1.1.2. Aeromedical Physiology** - (altitude physiology, flight physiology) Means the physiological changes imposed on humans when exposed to changes in altitude and atmospheric pressure and the physical forces of aircraft in flight. Persons whose physiologic state is already compromised may be more susceptible to these changes and the potential physiologic responses they may experience while in flight in an aircraft. It is directly related to physical gas laws and the physics of flight. See also Stressor of Flight.
- 3.1.1.3. Air Ambulance Aircraft** - (aircraft, airplane) Means a fixed-wing or rotor-wing aircraft specially constructed or modified, that is equipped and designated for transportation of sick or injured persons. It does not include transport of organ transplant teams or organs.
- 3.1.1.4. Air Ambulance Service** - (service, provider) Means an entity or a division of an entity (sole proprietorship, partnership or corporation) that is authorized by the Federal Aviation Administration (FAA) and DEMS to provide patient transport and/or transfer by air ambulance aircraft. The patient(s) may be ambulatory or non-ambulatory and may or may not require medical intervention of basic or advanced nature. It uses aircraft, equipped and staffed to provide a medical care environment on board appropriate to patient's needs. The term air ambulance service is not synonymous with and does not refer to the FAA air carrier certificate holder unless they also maintain and control the medical aspects that make up a complete service.
- 3.1.1.5. Air Medical Personnel** - Means a licensed physician, registered nurse, respiratory therapist, State of Mississippi current certified EMT-Paramedic, EMT-Intermediate or EMT-Basic who has successfully completed a course in aeromedical physiology and flight safety training and orientation.
- 3.1.1.6. Air Ambulance Transport System Activation** - Formerly referred to as

Dispatch, the term was changed to avoid conflict with the meaning in the FAR's - Means the process of receiving a request for transport or information and the act of allocating, sending and controlling an air ambulance and air medical personnel in response to such request as well as monitoring the progress of the transport.

- 3.1.1.7. **Authorized Representative** - Means any person delegated by a licensee to represent the provider to county, municipal or federal regulatory officials.
- 3.1.1.8. **Basic Life Support Care (BLSC)** - (BLS, basic care) Means the level of care (quantity and type of staff members(s), equipment and procedures) which is consistent with a stable patient in a non-acute situation who prior to transport may be in a skilled care setting or non-health care facility. The patient's condition will be such that he requires only minimal care such as monitoring of vital signs or administration of oxygen. It does not include patients with continuous IV infusions with or without additives or artificial airways. This level of care will be rendered by at least a basic level emergency medical technician. This level of care requires minimal equipment such as basic monitoring and diagnostic equipment - stethoscope, blood pressure cuff, flashlight, etc.
- 3.1.1.9. **Cockpit Crew Member** - (pilot, co-pilot, flight crew) Means a pilot, co-pilot, flight engineer, or flight navigator assigned to duty in an aircraft cockpit.
- 3.1.1.10. **Critical Care Life Support (CCLS)** - Means the level of care (quantity and type of staff member(s), equipment and procedures) that is consistent with a patient who may or may not be stable and who is in an acute situation or at high risk of decompensating prior to transport. The following patient categories are included: cardiovascular, pulmonary, neurologic, traumatic injury including spinal or head injury, burns, poisonings and toxicology. These patients are being cared for in an acute care facility such as the emergency department, intensive, critical, coronary or cardiac rhythm, oxygen saturation and maintenance of continuous infusions of IV medications or control of ventilatory functions by artificial means is being performed. This level of care must be rendered by at least two air medical personnel, one of which is a registered nurse or physician. This level of care requires specific monitoring and diagnostic equipment above the advanced level.
- 3.1.1.11. **FAA** - Means the Federal Aviation Administration.
- 3.1.1.12. **FAR** - Means the Federal Aviation Regulation.
- 3.1.1.13. **FCC** - Means the Federal Communications Commission.
- 3.1.1.14. **Fixed-wing Air Ambulance** - (fixed-wing) Means a fixed-wing type aircraft that is constructed or modified to transport at least one sick or injured patient in the supine or prone position on a medically appropriate, FAA approved stretcher. It also includes an array of medical equipment and an appropriate number of trained air medical personnel to care for the patient's needs.
- 3.1.1.15. **Inter-facility Transfer** - (transfer) Means the transportation of a patient, by an air ambulance service provider, initiating at a health care facility whose destination is another health care facility.
- 3.1.1.16. **Medical Director** - Means a licensed physician (MD or DO) who is specifically designated by an air ambulance provider and has accepted the responsibility for providing medical direction to the air ambulance service. ***He or she must be a Mississippi licensed physician, M.D. or D.O. who on or before July 1, 2005 has completed a state approved medical director training course or show evidence of board certification in emergency medicine or board eligibility in emergency***

medicine. Air Ambulances which operate from or based in Mississippi, must have a System medical director that must practice within the designated trauma care region or legal EMS district within which he/she is providing medical control. (Air Ambulance provided from and based out-of-state must have a system medical director that is board certified in emergency medicine or board eligible in emergency medicine.)

The medical director is ultimately responsible for all aspects of a service's operation which effect patient care. The medical director is responsible for assuring that appropriately trained medical personnel and equipment are provided for each patient transported and that individual aircraft can provide appropriate care environments for patients.

- 3.1.1.17. Patient** - Means an individual who is sick, injured, or otherwise incapacitated or whose condition requires or may require skilled medical care for intervention.
- 3.1.1.18. Permit** - Means a document issued by DEMS indicating that the aircraft has been approved for use as an air ambulance vehicle by DEMS in the state of Mississippi.
- 3.1.1.19. Physician - (doctor)** Means a person licensed to practice medicine as a physician (MD or DO) by the state where the air ambulance service is located.
- 3.1.1.20. Pilot** - Means a person who holds a valid certificate issued by the FAA to operate an aircraft.
- 3.1.1.21. Public Aircraft** - Means an aircraft used only in the service of a government agency. It does not include government-owned aircraft engaged in carrying persons or property for commercial purposes.
- 3.1.1.22. Reciprocal Licensing** - (reciprocity) means mutual acceptance of an air ambulance service provider's valid license to operate an air ambulance service in a state other than the one in which it is licensed.
- 3.1.1.23. Registered Nurse - (RN)** Means an individual who holds a valid license issued by the state licensing agency to practice professional nursing as a registered nurse.
- 3.1.1.24. Rotor-wing Air Ambulance - (rotor-wing)** Means a rotor-wing type aircraft that is constructed or modified to transport at least one sick or injured patient in the supine or prone position on a medically appropriate, FAA approved stretcher/litter (as per FAR Section 23.785 and 23.561). It also includes an array of medical equipment and an appropriate number of trained air medical personnel to care for the patient's needs.
- 3.1.1.25. Specialty Care Transport (SCS)** - Means the level of care (quantity and type of staff member(s), equipment and procedures) that is consistent with a patient whose condition requires special care specific to their age and/or diagnosis. The patient may or may not be stable or in an acute situation prior to transport. The following patient categories are included: pediatric intensive care, maternal care, neonatal intensive care and burn care.

Note: These patients are being cared for in an acute care facility environment such as the emergency department, coronary care unit, intensive care unit, pediatric or neonatal unit, burn care or other similar unit where continuous monitoring of vital signs, cardiac rhythm, oxygen saturation and maintenance of continuous infusions of IV medications or control of ventilatory functions by artificial means are being performed. This level of care must be rendered by medical personnel of appropriate training. This level of care requires monitoring and diagnostic equipment specific to the patients special care needs. Patients requiring this level of care should be identified during medical screening so that special staffing and equipment requirements can meet the patients potential needs. These patients are considered at risk for de-compensation during transport which may require close attention or intervention.

3.1.1.26. Stressors of Flight - Means the factors which humans may be exposed to during flight which can have an effect on the individual's physiologic state and ability to perform. The stressors include - hypoxia, barometric changes (expanding and contracting gas), fatigue (sometimes self induced), thermal variations (extremes of temperature), dehydration, noise, vibration, motion and G-forces.

3.2 Licensing

3.2.1. Licensure as an air ambulance service shall only be granted to a person or entity that directs and controls the integrated activities of both the medical and aviation components.

Note: Air ambulance requires the teaming of medical and aviation functions. In many instances, the entity that is providing the medical staffing, equipment and control is not the certificate aircraft operator but has an arrangement with another entity to provide the aircraft. Although the aircraft operator is directly responsible to the FAA for the operation of the aircraft, one organization, typically the one in charge of the medical functions, directs the combined efforts of the aviation and medical components during patient transport operations.

3.2.2. No person or organization may operate an air ambulance service unless such person or organization has a valid license issued by DEMS. Any person desiring to provide air ambulance services shall, prior to operation, obtain a license from DEMS. To obtain such license, each applicant for an air ambulance license shall pay the required fee and submit an application on the prescribed air ambulance licensure application forms. The license shall automatically expire at the end of the licensing period.

3.2.3. Prior to operation as an air ambulance, the applicant shall obtain a permit for each aircraft it uses to provide its service.

3.2.4. Each licensee shall be able to provide air ambulance service within 90 days after receipt of its license to operate as an air ambulance from the licensing authority.

3.2.5. Each aircraft configured for patient transport shall meet the structural, equipment and supply requirements set forth in these regulations.

3.2.6. An air ambulance license is dependent on, and concurrent with, proper FAA certification of the aircraft operator(s) to concurrent with proper FAA certification of the aircraft

operator(s) to conduct operations under the applicable parts of the Federal Aviation Regulations (included are Parts 1, 43, 61, 67, 91, 135).

- 3.2.7. Current, full accreditation by the Commission on Accreditation of Air Medical Services (CAAMS) or equivalent program will be accepted by DEMS as compliance with the requirements set forth.
- 3.2.8. A provider's license will be suspended or revoked for failure to comply with the requirements of these regulations.
- 3.2.9. No licensee shall operate a service if their license has been suspended or revoked.
- 3.2.10. Any provider that maintains bases of operation in more than one state jurisdiction shall be licensed at each base by DEMS having jurisdiction.

3.3. Reciprocity

Any provider who is licensed in another jurisdiction whose regulations are at least as stringent as these, and provides proof of such license, and who meets all other regulatory requirements shall be regarded as meeting the specifications of these regulations.

3.4. Inspections

3.4.1. Access - Inspection of records; equipment/supply categories, and air ambulance aircraft.

- a. DEMS, after presenting proper identification, shall be allowed to inspect any aircraft, equipment, supplies or records of any licensee to determine compliance with these regulations. DEMS shall inspect the licensee at least twice every licensing period.
- b. The finding of any inspection shall be recorded on a form provided for this purpose. DEMS shall furnish a copy of the inspection report form to the licensee or the licensee's authorized representative. Upon completion of an inspection, any violations shall be noted on the form.

3.4.2. Issuance of Notices.

Whenever DEMS makes an inspection of an air ambulance aircraft and discovers that any of the requirements of these regulations have been violated or have not been complied with in any manner, DEMS shall notify the licensee of the infraction(s) by means of an inspection report or other written notice.

The report shall:

- a. Set forth the specific violations found;
- b. Establish a specific period of time for the correction of the violation(s) found, in accordance with the provisions in Violations.

3.5. Reports

- 3.5.1. Each holder of a license shall notify DEMS of the disposition of any criminal or civil litigation or arbitration based on their actions as a licensee within 5 days after a verdict has been rendered.
- 3.5.2. The licensee will notify DEMS when it removes a permitted aircraft from service or

replaces it with a substitute aircraft meeting the same transport capabilities and equipment specifications as the out-of-service aircraft for a period of time greater than 7 days but not to exceed 90 calendar days. Upon receipt of notification, DEMS shall issue a temporary permit for the operation of said aircraft.

- 3.5.3. Each licensee shall maintain accurate records upon such forms as may be provided, and contain such information as may be required by DEMS concerning the transportation of each patient within this state and beyond its limits. Such records shall be available for inspection by DEMS at any reasonable time, and copies thereof shall be furnished to DEMS upon request.

- 3.5.3.1. All licensed ambulance services operating in the State of Mississippi must **electronically** submit the State of Mississippi Patient Encounter Form and/or information contained on the form **via network, direct computer link or computer floppy disk** for each ambulance run made and/or for each patient transported. **Sufficient copies of the State of Mississippi Patient Encounter Form are furnished by DEMS for all licensed air ambulance services. Each service will be provided with one year's supply of these forms.**
- 3.5.3.2. ***A completed copy of a Mississippi Patient Encounter Form or Patient Care Report containing the data elements of the Mississippi Patient Encounter Form shall be left with hospital staff for all patients delivered to licensed Hospitals. If in the best interest of the public good, an immediate response to a patient is required of an ambulance delivering a patient to a licensed Hospital, a complete oral report on the patient being delivered will be given to the receiving facility and a completed copy of a Mississippi Patient Encounter Form or Patient Care Report containing the data elements of the Mississippi Patient Encounter Form for that patient shall be delivered in person or by fax to the hospital staff of the licensed Hospital within 24 hours.***
- 3.5.3.3. ***Mississippi Patient Encounter Forms*** ~~Computer disk or encounter forms~~ are due in the DEMS office by the seventh day after the close of the preceding month.
- 3.5.3.4. All encounter forms or computer disk information returned to a licensee for correction must be corrected and returned to the DEMS office within two weeks calculated from the date of their return.
- 3.5.3.5. Returns to a licensee greater than 3 times may result in a penalty as outlined under Section 41-59-45, paragraph 3.
- 3.5.3.6. The licensee shall maintain a copy of all the run records according to statutory requirements, accessible for inspection upon request by DEMS.
- 3.5.3.7. A copy of the patient encounter form shall be given to the person accepting care of the patient.

3.6. Location of Facilities

The Licensee shall identify on the prescribed form any and all physical locations where a function of their operations are conducted. These locations include: permanent business office, aircraft storage, repair, communications/activation facilities, training and sleeping areas.

3.7. Advertising

- 3.7.1. No person, entity or organization shall advertise via printed or electronic media as an air ambulance service provider in the state of Mississippi unless they hold a valid license in the state of Mississippi or has licensure in another state which is reciprocally honored by DEMS.
- 3.7.2. The licensee's advertising shall be done only under the name stated on their license.
- 3.7.3. The licensee's advertising and marketing shall demonstrate consistency with the licensee's actual licensed level of medical care capabilities and aircraft resources. The name of the Air Carrier Operating Certificate holder shall be listed if the licensee leases or otherwise does not operate the aircraft under their own Air Carrier certificate.

3.8. Insurance Coverage Required

3.8.1. Property & Casualty Liability

Every licensee or applicant shall ensure that the Part 135 Air Carrier Operating certificate holder operating the aircraft carries bodily injury and property damage insurance with solvent insurers licensed to do business in the state of Mississippi, to secure payment for any loss or damage resulting from any occurrence arising out of or caused by the operation or use of any of the certificate holders aircraft. Each aircraft shall be insured for the minimum amount of \$1,000,000 for injuries to, or death of, any one person arising out of any one incident or accident; the minimum amount of \$3,000,000 for injuries to, or death of, more than one person in any one accident; and, for the minimum amount of \$500,000 for damage to property from any one accident.

- 3.8.2 Government-operated service aircraft shall be insured for the sum of at least \$500,000 for any claim or judgment and the sum of \$1,000,000 total for all claims or judgments arising out of the same occurrence. Every insurance policy or contract for such insurance shall provide for the payment and satisfaction of any financial judgment entered against the licensee or any aircraft owner or pilot(s) operating the insured aircraft. All such insurance policies shall provide for a certificate of insurance to be issued to DEMS.

3.8.3. Professional Medical Liability (Malpractice)

Every air ambulance licensee or applicant shall carry professional liability coverage with solvent insurers licensed to do business in the state of Mississippi, to secure payment for any loss or damage resulting from any occurrence arising out of or caused by the care or lack of care of a patient. The licensee or applicant shall maintain professional liability coverage in the minimum amount of \$500,000 per occurrence.

- 3.8.4. In lieu of such insurance, the licensee or applicant may furnish a certificate of self-insurance establishing that the licensee or applicant has a self-insurance plan to cover such risks and that the plan has been approved by the State of Mississippi Insurance Commissioner.

3.9. Aircraft Permits Required

- 3.9.1. DEMS shall issue a permit to the licensee when the licensee initially places the aircraft into service or when the licensee changes the level of service relative to that aircraft. The permit shall remain valid as long as the aircraft is operated or leased by the licensee

subject to the following conditions:

- 3.9.1.1. The licensee submits an aircraft permit application for the aircraft and pays the required fees.
- 3.9.1.2. Permits issued by DEMS for an aircraft pursuant to this rule shall be carried inboard the aircraft and readily available for inspection.
- 3.9.1.3. If ownership of any permitted aircraft is transferred to any other person or entity, the permit is void and the licensee shall remove the permit from the aircraft at the time the aircraft is transferred and return the permit to the licensing authority within 10 days of the transfer.
- 3.9.1.4. If a substitute aircraft is in service for longer than 90 days, this aircraft shall be required to be permitted. An un-permitted aircraft cannot be placed into service, nor can an aircraft be used unless it is replacing aircraft that has been temporarily taken out of service.

When such a substitution is made, the following information shall be maintained by the licensee and shall be accessible to DEMS:

- (1) Registration number of permitted aircraft taken out of service.
- (2) Registration number of substitute aircraft.
- (3) The date on which the substitute aircraft was placed into service and the date on which it was removed from service and the date on which the permitted aircraft was returned to service.

- 3.9.1.5. Aircraft permits are not transferable.
- 3.9.1.6. Duplicate aircraft permits can be obtained by submitting a written request to DEMS. The request shall include a letter signed by the licensee certifying that the original permit has been lost, destroyed or rendered unusable.
- 3.9.1.7. Each licensee shall obtain a new aircraft permit from DEMS prior to returning an aircraft to service following a modification, change or any renovation that results in a change to the stretcher placement or seating in the aircraft's interior configuration.
- 3.9.1.8. The holder of a permit to operate an air ambulance service, shall file an amended list of its permitted aircraft with DEMS within 10 days after an air ambulance is removed permanently from service.

3.10. Off-Line and On-Line Medical Direction

3.10.1. Off-Line Medical Direction

3.10.1.1. Qualifications

- 3.10.1.1.1. Each air ambulance service shall designate or employ an off-line medical director. The off-line medical director shall meet the following qualifications:
- 3.10.1.1.2. The off-line medical director shall be a physician (MD or DO) currently licensed and in practice.
- 3.10.1.1.3. The physician shall be licensed to practice medicine in the state(s) where the service is domiciled.
- 3.10.1.1.4. Services having multiple bases of operation shall have an off-line medical director for each base. If the off-line medical director for the service's primary location is licensed in the state where the base(s) is/are located, they may function as the off-line medical director for that base in place of a separate individual.

3.10.1.1.5. ***Must be a Mississippi licensed physician, M.D. or D.O. who on or before July 1, 2005 has completed a state approved medical director training course or show evidence of board certification in emergency medicine or board eligibility in emergency medicine. Air Ambulances which operate from or based in Mississippi, must have a System medical director that must practice within the designated trauma care region or legal EMS district within which he/she is providing medical control. (Air Ambulance provided from and based out-of-state must have a system medical director that is board certified in emergency medicine or board eligible in emergency medicine.)***

3.10.1.1.6. The off-line medical director shall have knowledge and experience consistent with the transport of patient's by air.

3.10.2. Responsibilities

3.10.2.1. The physician shall be knowledgeable in aeromedical physiology, stresses of flight, aircraft safety, patient care, and resource limitations of the aircraft, medical staff and equipment.

3.10.2.2. The off-line medical director shall have access to consult with medical specialists for patient(s) whose illness and care needs are outside his/her area of practice.

3.10.2.3. The off-line medical director shall ensure that there is a comprehensive plan/policy to address selection of appropriate aircraft, staffing and equipment.

3.10.2.4. The off-line medical director shall be involved in the selection, hiring, training and continuing education of all medical personnel.

3.10.2.5. The off-line medical director shall be responsible for overseeing the development and maintenance of a quality assurance or a continuous quality improvement program.

3.10.2.6. The off-line medical director shall ensure that there is a plan to provide direction of patient care to the air medical personnel during transport. The system shall include on-line (radio/telephone) medical control, and/or an appropriate system for off-line medical control such as written guidelines, protocols, procedures patient specific written orders or standing orders.

3.10.2.7. The off-line medical director shall participate in any administrative decision making processes that affects patient care.

3.10.2.8. The off-line medical director will ensure that there is an adequate method for on-line medical control, and that there is a well defined plan or procedure and resources in place to allow off-line medical control.

3.10.2.9. In the case where written policies are instituted for medical control, the off-line medical director will oversee the review, revision and validation of them annually.

3.10.3. On-line Medical Control

The licensee's off-line medical director shall ensure that there is a capability and method to provide on-line medical control to air medical personnel on board any of its air ambulance aircraft at all times. If patient specific orders are written, there shall be a formal procedure to use them. In addition to on-line medical control capabilities, the licensee shall have a written plan, procedure and resources in place for off-line medical control. This may be accomplished by use of comprehensive written, guidelines, procedures or protocols.

3.11. Continuous Quality Improvement (CQI) Program

The licensee shall have an ongoing collaborative process within the organization that identifies issues affecting patient care.

- 3.11.1. These issues should address the effectiveness and efficiency of the organization, its support systems, as well as that of individuals within the organization.
- 3.11.2. When an issue is identified, a method of information gathering shall be developed. This shall include outcome studies, chart review, case discussion, or other methodology.
- 3.11.3. Findings, conclusions, recommendations and actions shall be made and recorded. Follow-up, if necessary, shall be determined, recorded, and performed.
- 3.11.4. Training and education needs, individual performance evaluations, equipment or resource acquisition, safety and risk management issues all shall be integrated with the CQI process.

3.12. Air Medical Personnel Licensing

There shall be at least one licensed air medical person on board an air ambulance to perform patient care duties on that air ambulance. The requirements for air medical personnel shall consist of not less than the following:

- 3.12.1. A valid license or certificate to practice their level of care (MD, DO, RN, EMT-B, EMT-I, EMT-P, RT) in the state; and possess as applicable to their scope of practice current Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS) and Pre-hospital Trauma Life Support (PHTLS) or Basic Trauma Life Support (BTLS) certifications.

Note: The requirements of this section are established in regard to scope of practice for air medical personnel and the mission of the air ambulance service. The medical director of the service will outline requirements in the medical control plan of the service and upon approval of DEMS, verification of these requirements will be the documentation required.

- 3.12.2. Documentation of successful completion of training as outlined in Training-Medical Attendants.
- 3.12.3. The licensee shall maintain documentation of each attendant's training and qualifications and shall insure that the attendant meets the continuing education requirements for their licensed specialty.

3.13. Required Staffing

- 3.13.1. When an aircraft is in service as an air ambulance, it will be staffed according to the level of care being provided:
 - 3.13.1.1. Basic level care (BLS) requires at least one state of Mississippi current certified basic level EMT.
 - 3.13.1.2. Advanced level care (ALS) - Intermediate

- a. Fixed-wing aircraft requires at least two personnel, one of which must be at least a state of Mississippi current certified Intermediate.
 - b. Rotor-wing aircraft requires at least a state of Mississippi current certified Intermediate.
- 3.13.1.3. Advanced level care (ALS) - Paramedic
- a. Fixed-wing aircraft requires at least two personnel, one of which must be at least a state of Mississippi current certified Paramedic.
 - b. Rotor-wing aircraft requires at least a state of Mississippi current certified Paramedic.
- 3.13.1.4. Critical care (CCLS) requires at least two personnel, one of which must be at least a registered nurse, or physician.
- 3.13.1.5. Additional medical staff not licensed as air medical personnel can be added to or in place of licensed air medical personnel as long as at least one licensed air medical personnel with the highest level of certification (EMT-B, EMT-I, EMT-P, RN) required to care for the patient is also on board.
- 3.13.1.6. Air medical personnel will not assume cockpit duties when it may interfere with patient care responsibilities.
- 3.13.1.7. The aircraft shall be operated by a pilot or pilots certified in accordance with applicable FAR's. The captain or pilot in command will meet the following requirements:
- 3.13.1.8. Fixed-wing air ambulance
- a. Has accumulated at least 2000 hours total time as a pilot.
 - b. Has accumulated at least 1000 hours as pilot in command of an airplane.
 - c. Must have accumulated at least 500 hours as pilot of a multi-engine aircraft.
 - d. Has accumulated at least 25 hours as pilot in command of the specific make and model of aircraft being used as an air ambulance.
 - e. Possess an Airline Transport certificate.
- 3.13.1.9. Rotor-wing air ambulance
- a. Has accumulated at least 2000 rotor craft flight hours total time as a pilot.
 - b. At least 1000 of those hours must be as pilot in command.
 - c. At least 100 of those hours must be night-flight time.
 - d. Factory school or equivalent in aircraft type (ground and flight).
 - e. Has accumulated 5 hours in aircraft type as pilot in command or at the controls prior to EMS missions if transitioning from a single engine to a single engine; from a twin engine to a single engine; or from a twin engine to a twin engine.
 - f. Has accumulated 10 hours as pilot in command or at the controls prior to EMS missions if transitioning from a single engine to a twin engine aircraft.
 - g. Must possess at least a commercial rotor craft-helicopter rating. ATP certificate is encouraged.
- 3.13.1.10. A First Officer or co-pilot, if used, will meet the following requirements:
- 3.13.1.11. Fixed-wing air ambulance
- a. Has accumulated at least 500 hours total time as a pilot.
 - b. Must have accumulated at least 100 hours as pilot of a multi-engine aircraft.

- c. Has accumulated at least 25 hours as pilot in command of the specific make and model of aircraft being used as an air ambulance.
 - d. Possess a Commercial Pilot certificate.
- 3.13.1.12. Rotor-wing air ambulance
- a. Has accumulated at least 500 rotor craft flight hours total time as a pilot.
 - b. Factory school or equivalent in aircraft type (ground and flight).
 - c. Must possess at least a commercial rotor craft-helicopter rating.

3.14. Training

3.14.1. Air Medical Personnel

The licensee shall ensure that all medical personnel receive orientation and training specific to their respective aircraft (fixed-wing or rotor-wing) transport environment in general and the licensee's operation specifically. The curriculum shall be consistent with the Department of Transportation (DOT) Air Medical Crew - National Standard Curriculum, or equivalent program.

- 3.14.1.1. Initial - The licensee shall ensure that all air medical personnel successfully complete initial training and orientation to their position including adequate instruction, practice and drills. This training will include the following topics:
- a. Aeromedical physiology, gas laws and stressors of flight.
 - b. Aircraft familiarization and flight safety.
 - (1) aircraft and cabin systems familiarization.
 - (2) operation of emergency exits, evacuation procedures and use of emergency equipment.
 - (3) location of medical equipment and supplies.
 - (4) enplaning, deplaning and securing of patients for flight.
 - (5) In flight procedures for normal conditions and emergencies such as cabin depressurization, smoke or fire in the cabin, fire suppression, electrical failures.
 - c. Medical equipment familiarization.
 - d. Patient care policies, procedures and protocols, standards of care, and patient assessment.
 - e. Documentation.
 - f. Local EMS system communication and medical conventions.
 - g. Survival.
 - h. Infection control including OSHA blood borne pathogens.
 - i. Pharmacology.
 - j. Hazardous materials.
 - k. Legal and ethical issues
- 3.14.1.2. Recurrent - The licensee shall ensure that all air medical personnel shall successfully complete training consistent with the requirements set forth in the previous section annually.
- 3.14.1.3. Drills - The licensee shall make provisions for actual practice of those procedures that require complicated physical work or those that are technically complex such as enplaning and deplaning of patients, emergency evacuation, medical equipment identification, mock situational problem annually.
- 3.14.1.4. Documentation - The licensee will document the completed training for each air medical staff member.

3.14.2. **Flight Crew Member**

The licensee shall have a structured program of initial and recurrent training for the aviation personnel specific to their function in the medical transport environment. The aviation specific requirements of FAR (section 135.345) are controlling, however, DEMS recommended guidelines are listed below:

- 3.14.2.1. Initial - The licensee shall ensure that all cockpit crew members successfully complete initial training and orientation to the skills and knowledge necessary to perform their functions in air medical transport operations. Training shall include the following topics:
- a. Pre-flight planning to accommodate special patient needs including weather considerations, altitude selection, fuel requirements, weight and balance, effective range and performance and selection of alternate airports appropriate for a medial or aviation diversion.
 - b. Flight release - effective communication between communications specialist, air medical personnel and pilot(s). Aviation considerations for release (approval to proceed) based on the latest weather and aircraft status.
 - c. Ground ambulance handling in direct vicinity of aircraft.
 - d. Baggage and equipment handling (pressurized and non-pressurized compartments)(fixed-wing pilots)
 - e. Patient enplaning - passenger briefing. (fixed-wing pilots)
 - f. Coordination of aircraft movement with air medical personnel activities prior to taxi to ensure their safety.
 - g. Smooth and coordinated control of the aircraft when maneuvering, transition of control surface configurations and ground operations for patient, air medical personnel and passenger comfort.
 - h. Intermediate stop procedures - (fueling, fire equipment standby, customs).
 - i. Medical emergencies during flight.
 - j. Aircraft emergency procedures - evacuations including patient.
 - k. Cabin temperature control to maintain comfortable cabin temperature for the occupants.
- 3.14.2.2. Recurrent - The licensee shall ensure that all aviation personnel receive recurrent training - at least annually - on the topics included in their initial indoctrination as well as any changes or updates made to policies or procedures.
- 3.14.2.3. Drills - The licensee shall make provisions for actual practice of those procedures that require complicated physical work or that are technically complex such as enplaning and deplaning of patients, emergency evacuation, medical equipment identification, and mock situational problem solving.
- 3.14.2.4. Documentation - The licensee will document the completed training for each air medical staff member.

3.15. **Communications**

The licensee shall have facilities and plans in place to provide the telephonic and radio systems necessary to carry verbal communication. The system should be consistent with the services scope of care and includes three elements: receipt of incoming inquiries and transport requests; activation and communications with aircraft flight crews and air medical personnel during transport operations; and medical control communications.

3.15.1. Activation Capability

- 3.15.1.1. Initial contact/coordination point - The licensee shall have a plan to receive requests for service and assign resources to handle the transport requests.
- 3.15.1.2. Contact data resources - The licensee shall maintain an information file available to the person handling communications that contains the necessary contact person's phone numbers and other pertinent data to manage routine and emergency communication needs.
- 3.15.1.3. Documentation - The licensee shall record the chronological events of each transport. The following data elements shall be included:
 - a. Time of initial request
 - b. Time of aircraft liftoff
 - c. Time of aircraft arrival at pickup point
 - d. Time of aircraft liftoff
 - e. Time of any intermediate aircraft stops
 - f. Time of aircraft arrival at destination
 - g. Time aircraft and crew are returned to service and available.

3.15.2. Communications Continuity and Flight Following Capability

There shall be a well defined process to track transport activities and provide the necessary support to efficiently follow aircraft, flight crews and air medical personnel movement. The licensee shall have a written emergency plan which addresses the actions to be taken in the event of an aircraft incident or accident, breakdown or patient deterioration during transport operations.

3.15.3. Medical Control Communications

The licensee shall have a means of providing communications between the aircraft, the coordination point, medical control personnel and other agencies by telephonic or radio as appropriate. This shall be accomplished by local or regional EMS radio systems; and/or radio or flight phone as available inboard the aircraft. All aircraft shall have 155.340 statewide hospital net available for air crew member(s) in the patient area.

3.16. Requirements For Aircraft

When being used as an air ambulance, in addition to meeting other requirements set forth in these rules, and aircraft shall:

- 3.16.1. Be multi-engine. (Fixed-wing)
- 3.16.2. Be pressurized. (Fixed-wing)
- 3.16.3. Be equipped for IFR flight.

Note: Fixed-wing aircraft should be equipped and rated for IFR operations in accordance with FAR's. Rotor-wing aircraft should be equipped for inadvertent IFR if operating as a VFR operator.

- 3.16.4. Have a door large enough to allow a patient on a stretcher to be enplaned without excessive maneuvering or tipping of the patient which compromises the function of monitoring devices, IV lines or ventilation equipment.

- 3.16.5. Be designed or modified to accommodate at least 1 stretcher patient.
- 3.16.6. Have a lighting system which can provide adequate intensity to illuminate the patient care area and an adequate method (curtain, distance) to limit the cabin light from entering the cockpit and impeding cockpit crew vision during night operations.
- 3.16.7. Have an environmental system (heating and cooling) capable of maintaining a comfortable temperature at all times. (Fixed-wing)
- 3.16.8. Have an interior cabin configuration large enough to accommodate the number of air medical personnel needed to provide care to the patient in accordance with Required Staffing, as well as an adult stretcher in the cabin area with access to the patient. The configuration shall not impede the normal or emergency evacuation routes.
- 3.16.9. Have an electrical system capable of servicing the power needs of electrically powered on-board patient care equipment.
- 3.16.10. Have all installed and carry on equipment secured using FAA approved devices and methods.
- 3.16.11. Have sufficient space in the cabin area where the patient stretcher is installed so that equipment can be stored and secured with FAA approved devices in such a manner that it is accessible to the air medical personnel.
- 3.16.12. Have two fire extinguishers approved for aircraft use. Each shall be fully charged with valid inspection certification and capable of extinguishing type A, B or C fires. One extinguisher shall be accessible to the cockpit crew and one shall be in the cabin area accessible to the medical crew members. (fixed-wing)
One fire extinguisher type A, B or C, fully charged with valid inspection, shall be accessible to the cockpit crew and cabin area medical crew members. If not accessible, two fire extinguishers are required. (rotor-wing)

3.17. Medical Equipment & Supplies

Each air ambulance aircraft shall carry the following minimum equipment set forth in the following section unless a substitution is approved by DEMS and an off-line medical director.

3.17.1. Medical Equipment for All Levels of Care Shall Include:

- 3.17.1.1. Stretcher - There shall be 1 or more stretcher(s) installed in the aircraft cabin which meets the following criteria:
- 3.17.1.1.1. Can accommodate a patient who is in the 95 percentile for an adult male - 6 feet tall, 212 lbs. or 96.2 kg. There shall be restraining devices or additional appliances available to provide adequate restraint of patients under 60 lbs or 36" in height.
- 3.17.1.1.2. Shall have at least two cross-body patient restraining straps, one of which secures

the chest area and the other about the area of the knee and thigh area. If the patient(s) is/are secured in the aircraft with his/their head toward the nose of the aircraft, there shall be a harness which goes over the shoulders to secure him/them from forward movement.

- 3.17.1.1.3. The stretcher shall be installed in the aircraft cabin so that it is sufficiently isolated by distance or physical barrier from the cockpit so that the patient cannot reach the cockpit crew from a supine or prone position on the stretcher.
- 3.17.1.1.4. Attachment points of the stretcher to the aircraft, the stretcher itself, and the straps securing the patient to the stretcher, shall meet FAR Part 23 restraint requirements.
- 3.17.1.1.5. The head of each stretcher shall be capable of being elevated up to 45 degrees. The elevating section must hinge at or near the patient's hips and shall not interfere with or require that the patient or stretcher securing straps and hardware be removed or loosened. (fixed-wing)
- 3.17.1.1.6. The stretcher shall be positioned in the cabin to allow the air medical personnel clear view of the patient's body.
- 3.17.1.1.7. Air medical personnel shall always have access to the patient's head and upper body for airway control procedures as well as sufficient space over the area where the patient's chest is to adequately perform closed chest compression or abdominal thrusts on the patient.

Note: The licensee may be required to demonstrate to the licensing authority that airway control procedures and cardiac compressions/abdominal thrusts can be adequately performed on a training manikin in any of its aircraft.

- 3.17.1.1.8. The stretcher pad or mattress shall be impervious to moisture and easily cleaned and disinfected according to OSHA blood borne pathogens requirements.
- 3.17.1.1.9. If the surface of the stretcher under the patients torso is not firm enough to support adequate chest compressions, a device to make the surface rigid enough will be provided.
- 3.17.1.1.10. A supply of linen for each patient.

3.17.2. Respiratory Care

- 3.17.2.1. OXYGEN - An adequate and manually controlled supply of gaseous or liquid medical oxygen, attachments for humidification, and a variable flow regulator for each patient. A humidifier, if used, shall be a sterile, disposable, one-time usage item. The licensee shall have and demonstrate the method used to calculate the volume of oxygen required to provide sufficient oxygen for the patients needs for the duration of the transport. The licensee will have a plan to provide the calculated volume of oxygen plus a reserve equal 1000 liters or the volume required to reach an appropriate airport whichever is longer. All necessary regulators, gauges and accessories shall be present and in good working order. The system shall be securely fastened to the airframe using FAA approved restraining devices.
- 3.17.2.1.1. A separate emergency backup supply of oxygen of not less than one E cylinder with regulator and flow meter.

Note: "D" cylinder with regulator and flow meter is permissible for rotor-wing aircraft in place of the "E" cylinder requirement.

- 3.17.2.2. 1 adult and 1 pediatric size non-rebreathing oxygen mask; 1 adult size nasal cannula and necessary connective tubing and appliances.
- 3.17.2.3. SUCTION - As the primary source, an electrically powered suction apparatus with wide bore tubing, a large reservoir and various sizes suction catheters. The suction system can be built into the aircraft or provided with a portable unit. Backup suction is required and can be a manually operated device.
- 3.17.2.4. BAG-VALVE-MASK - Hand operated bag-valve-mask ventilators of adult, pediatric and infant size with clear masks in adult, pediatric and infant sizes. It shall be capable of use with a supplemental oxygen supply and have an oxygen reservoir.
- 3.17.2.5. AIRWAY ADJUNCTS
- 3.17.2.5.1. Oropharyngeal airways in at least 5 assorted sizes, including adult, child, and infant.
- 3.17.2.5.2. Nasopharyngeal airways in at least 3 sizes with water soluble lubricant.

3.17.3. **Patient Assessment Equipment**

- 3.17.3.1. Equipment suitable to determine blood pressure of the adult, pediatric and infant patient(s) during flight.
- 3.17.3.2. Stethoscope.
- 3.17.3.3. Penlight/Flashlight.
- 3.17.3.4. Bandage scissors, heavy duty.

3.17.4. **Pulse Oximeter**

3.17.5. **Bandages & Dressings**

- 3.17.5.1. Sterile Dressings such as 4x4's, ABD pads.
- 3.17.5.2. Bandages such as Kerlix, Kling.
- 3.17.5.3. Tape - various sizes.

3.17.6. **Miscellaneous Equipment and Supplies**

- 3.17.6.1. Potable or sterile water.
- 3.17.6.2. Container(s) and methods to collect, contain and dispose of body fluids such as emesis, oral secretions and blood consistent with OSHA blood borne pathogens requirements.
- 3.17.6.3. Infection control equipment.
The licensee shall have a sufficient quantity of the following supplies for all air medical personnel, each flight crew member and all ground personnel with incidental exposure risks according to OSHA requirements:
 - 3.17.6.3.1. Latex gloves.
 - 3.17.6.3.2. Protective gowns.
 - 3.17.6.3.3. Protective goggles.
 - 3.17.6.3.4. Protective face masks.
 - 3.17.6.3.5. There shall be an approved bio-hazardous waste plastic bag or impervious

- container to receive and dispose of used supplies.
- 3.17.6.3.6. Hand washing capabilities or antiviral towellets.
- 3.17.6.3.7. An adequate trash disposal system exclusive of bio-hazardous waste control provisions.
- 3.17.6.3.8. Survival Kit - the licensee shall maintain supplies to be used in a survival situation. It shall include, but not be limited to, the following items which are appropriate to the terrain and environments the licensee operates over:
 - 3.17.6.3.8.1. Instruction manual.
 - 3.17.6.3.8.2. Water.
 - 3.17.6.3.8.3. Shelter - space blanket.
 - 3.17.6.3.8.4. Knife.
 - 3.17.6.3.8.5. Signaling device - mirror, whistle, flares, dye marker.
 - 3.17.6.3.8.6. Compass.
 - 3.17.6.3.8.7. Fire starting items - matches, candle, flint, battery.

3.17.7. **TO FUNCTION AT THE ALS LEVEL**, the following additional equipment is required:

3.17.7.1. **Endotracheal Intubation Equipment:**

- 3.17.7.1.1. Laryngoscope handle.
- 3.17.7.1.2. One each adult, pediatric and infant blades.
- 3.17.7.1.3. Two of each size of assorted disposable endotracheal tubes according to the scope of the licensee's service and patient mixture with assorted stylets, syringes.
- 3.17.7.1.4. ***End-tidal CO2 detectors (may be made onto bag valve mask assemblies or separate)***
- 3.17.7.1.5. Alternate airway management equipment.

3.17.7.2. **IV Equipment and Supplies**

- 3.17.7.2.1. Sterile crystalloid solutions in plastic containers, IV catheters, and administration tubing sets.
- 3.17.7.2.2. Hanger for IV solutions.
- 3.17.7.2.3. A device for applying external pressure to a flexible IV fluid containers.
- 3.17.7.2.4. Tourniquets, tape, dressings.
- 3.17.7.2.5. Suitable equipment and supplies to allow for collection and temporary storage of two blood samples.
- 3.17.7.2.6. A container appropriate to contain used sharp devices - needles, scalpels which meets OSHA requirements.

3.17.7.3. **Medications**

- 3.17.7.3.1. Security of medications, fluids and controlled substances shall be maintained by each air ambulance licensee. Security procedures shall be approved by the service's medical director and be in compliance with the licensee's policies and procedures. Medication inventory techniques and schedules shall be maintained in compliance with all applicable local, state and federal drug laws.
- 3.17.7.3.2. Medication inventory:

<u>QUANTITY</u>	<u>MEDICATION</u>	<u>CONCENTRATION</u>
-----------------	-------------------	----------------------

2	Atropine	1mg/10ml
4	Aminophylline	250mg/10ml
2	Benadryl	5mg/ml
2	Bretylum	500mg/10ml
2	Calcium Chloride	1mg/10ml
2	Dextrose 50%	25gm/50ml
2	Dramamine (fixed-wing only)	50mg/ml
25	Dramamine (fixed-wing only)	50mg/tab
1	Dopamine	400mg/5ml or 400mg/250ml D5W
4	Epinephrine 1:10,000	1mg/10ml
2	Epinephrine 1:1,000	1mg/1ml
1	Isuprel	1mg/5ml or 10 ml
8 or 4	Lasix	20mg/2ml or 10mg/4ml
2	Lidocaine	100mg/5ml or 10 ml
2 or 1	Lidocaine	1gm/5ml or 10ml or 2gm/500ml D5W
2	Narcan	1mg/2ml
1	Nitroglycerin	1/150gr tabs or 0.4mg/metered dose spray
4	Sodium Bicarbonate	50mg/50ml

- 3.17.7.3.3. The medical director can modify the medication inventory as required to meet the care needs of their patient mix and in compliance with section (3.17.7.3.5.) below.
- 3.17.7.3.4. The licensee shall have a sufficient quantity of needles, syringes and accessories necessary to administer the medications in the inventory supply.
- 3.17.7.3.5. The medical director of the licensee may authorize the licensee with justification to substitute medication(s) listed provided that he first obtains approval from DEMS, and provided further that he signs such authorization.
- 3.17.7.4. **Cardiac Monitor-Defibrillator** - D.C. battery powered portable monitor/defibrillator with paper printout and spare batteries, accessories and supplies.

- 3.17.7.5. **External Cardiac Pacing Device**
- 3.17.7.6. **Non-Invasive Automatic Blood Pressure Monitor**
- 3.17.7.7. **IV Infusion Pump** capable of strict mechanical control of an IV infusion drip rate. Passive devices such as dial-a-flows are not acceptable.
- 3.17.7.8. **Electronic Monitoring Devices** - Any electronic or electrically powered medical equipment to be used on board an aircraft should be tested prior to actual patient use to insure that it does not produce Radio Frequency Interference (RFI) or Electro Magnetic Interference (EMI) which would interfere with aircraft radio communications or radio navigation systems. This may be accomplished by reference to test data from organizations such as the military or by actual tests performed by the licensee while airborne.
- 3.17.8. **TO FUNCTION AT THE CCLS OR SPECIALTY LEVEL OF CARE**, the following additional equipment shall be available as required:
- 3.17.8.1. **Mechanical Ventilator** - A mechanical ventilator that can deliver up to 100% oxygen concentration at pressures, rates and volumes appropriate for the size of patient being cared for.
- 3.17.8.2. **Isolette** - for services performing transport of neonatal patients.
- 3.17.8.3. **Intraaortic Balloon Pump (IABP)**
- 3.17.8.4. **Invasive Line (ARTERIAL AND SWAN-GANZ CATHETERS) monitoring capability.**

3.18. **Equipment Maintenance and Inspection Program**

- 3.18.1. The licensee shall have a program to inspect and maintain the effective operation of its medical equipment. The program should include daily or periodic function checks and routine preventive inspection and maintenance. There should be a plan for securing replacement or backup equipment when individual items are in for repair. There should be manufacturer's manuals as well as brief checklist available for reference. The equipment maintenance and inspection program shall include:
- 3.18.2. Daily or periodic checks - shall include a checklist based on the manufacturer's recommendations which verifies proper equipment function and sterile package integrity.
- 3.18.3. Routine preventive maintenance - shall include a program of cleaning and validating proper performance, supply packaging integrity.
- 3.18.4. A documentation system which tracks the history of each equipment item.
- 3.18.5. A procedure for reporting defective or malfunctioning equipment when patient care has been effected.

3.19. VIOLATIONS

3.19.1. Violations should be corrected at the time of the inspection, if possible.

3.19.2. Violations of the requirements set forth in this section will require appropriate corrective action by the licensee.

3.19.3. Category "A" violations require the air ambulance aircraft be immediately removed from service until it has been reinspected and found to be in compliance with these regulations.

Category "A" violations include:

3.19.3.1. Missing equipment or disposable supply items.

3.19.3.2. Insufficient number of trained air medical personnel to fill the services staffing requirements.

3.19.3.3. The provider has no medical director.

3.19.3.4. Violation or non-compliance of FAR or OSHA mandates.

3.19.4. Category "B" violations must be corrected within 72 hours of receiving notice and a written report shall be sent to DEMS verifying the correction. Category "B" violations include:

3.19.4.1. Unclean or unsanitary equipment or aircraft environment.

3.19.4.2. Non-functional or improperly functioning equipment.

3.19.4.3. Expired shelf life of supplies such as medications, IV fluids and items having limited shelf life.

3.19.4.4. Package integrity of sealed or sterile items is compromised.

3.19.4.5. Failure to produce requested documentation of patient records, attendant training or other reports required by DEMS.

3.19.5. Suspension, Revocation of License may also occur as outlined in 41-59-17 and 41-59-45. Appeals from decision of the board can also be referred to in 41-59-49.

Appendix 1

Section IV



Medical Direction Standard Practice For Qualifications, Responsibilities, And Authority

4.1 Medical Direction (pre-hospital Emergency Medical Services)

All aspects of the organization and provision of emergency medical services (EMS), including both **medical first responders**, basic and advanced life support, require the active involvement and participation of physicians. These aspects should incorporate design of the EMS system prior to its implementation; continual revisions of the system; and operation of the system from initial access, to pre-hospital contact with the patient, through stabilization in the emergency department. All pre-hospital medical care may be considered to have been provided by one or more agents of the physician who controls the pre-hospital system, for this physician has assumed responsibility for such care. Implementation of this standard practice will insure that the EMS system has the authority, commensurate with the responsibility, to insure adequate medical direction of all pre-hospital providers, as well as personnel and facilities that meet minimum criteria to implement medical direction of pre-hospital services.

4.2 Medical Direction (Off-Line A.K.A. System Medical Director)

4.2.1. Medical Director of licensed ambulance service, Off-Line (A.K.A. System Medical Director).

Each **EMS agency licensed ambulance service** providing pre-hospital care shall be licensed by the Mississippi State Department of Health, DEMS, and shall have an identifiable **system** Medical Director who after consultation with others involved and interested in the agency is responsible for the development, implementation and evaluation of standards for provision for medical care within the agency.

- 4.2.1.1. All pre-hospital providers (**including EMT-Bs**) shall be medically accountable for their actions and are responsible to the **system** Medical Director of the licensed **EMS agency ambulance service** that approves their continued participation. All pre-hospital providers, with levels of certification EMT-B or above, shall be responsible to an identifiable physician who directs their medical care activity. The **system** Medical Director shall be appointed by, and accountable to, the appropriate licensed **EMS agency ambulance service**.

- 4.2.1.2. System Medical Director - non transport, off-line (A.K.A. System Medical Director)

- 4.2.1.3. **Each non-transport pre-hospital provider shall have an identifiable medical director who, after consultation with others involved and interested in the non-transport agency is responsible for the development, implementation and evaluation of standards for provision for medical care within the non transport agency. All non- transport pre-hospital providers shall be medically accountable for their actions and are responsible to the system medical director of the non transport agency that approves their continued participation. All non-transport pre-hospital providers, with levels of certification medical first responder or above, shall be responsible to an identifiable physician who directs their medical care activities.**

- 4.2.1.4. Requirements of a System Medical Director

The medical aspects of an emergency medical service system shall be managed by physicians who meet the following requirements:

- 4.2.1.4.1. **Mississippi licensed physician, M.D. or D.O. who on or before July 1, 2005 has completed a state approved medical director training course or**

show evidence of board certification in emergency medicine or board eligibility in emergency medicine. System medical direction must practice within the designated trauma care region or legal EMS district within which he/she is providing medical control.

- 4.2.1.4.2. Experience in, and current knowledge of, emergency care of patients who are acutely ill or traumatized.
- 4.2.1.4.3. Knowledge of, and access to, local mass casualty plans.
- 4.2.1.4.4. Familiarity with base station operations where applicable, including communication with, and direction of, pre-hospital emergency units.
- 4.2.1.4.5. Active involvement in the training of pre-hospital personnel.
- 4.2.1.4.6. Active involvement in the medical audit, review and critique of medical care provided by pre-hospital personnel.
- 4.2.1.4.7. Knowledgeable of the administrative and legislative process affecting the local, regional and/or state pre-hospital EMS system.
- 4.2.1.4.8. Knowledgeable of laws and regulations affecting local, regional and state EMS.

- 4.2.1.5. Authority of a Medical Director includes, but is not limited to:
 - 4.2.1.5.1. Establishing system-wide medical protocols in consultation with appropriate specialists.
 - 4.2.1.5.2. Establishment of system-wide trauma protocols as delineated by the State Trauma Care Plan.
 - 4.2.1.5.3. Recommending certification or decertification of non-physician pre-hospital personnel to the appropriate certifying agencies. Every licensed agency shall have an appropriate review and appeals mechanism, when decertification is recommended, to assure due process in accordance with law and established local policies. The Director shall promptly refer the case to the appeals mechanism for review, if requested.
 - 4.2.1.5.4. Requiring education to the level of approved proficiency for personnel within the EMS system. This includes all pre-hospital personnel, EMTs at all levels, pre-hospital emergency care nurses, dispatchers, educational coordinators, and physician providers of on-line direction.
 - 4.2.1.5.5. Suspending a provider from medical care duties for due cause pending review and evaluation. Because the pre-hospital provider operates under the license (delegated practice) or direction of the Medical Director, the Director shall have ultimate authority to allow the pre-hospital provider to provide medical care within the pre-hospital phase of the EMS system.
 - 4.2.1.5.6. Establishing medical standards for dispatch procedures to assure that the appropriate EMS response unit(s) are dispatched to the medical emergency scene when requested, and the duty to evaluate the patient is fulfilled.
 - 4.2.1.5.7. Establishing under which circumstances a patient may be transported against his will; in accordance with, state law including, procedures, appropriate forms and review process.
 - 4.2.1.5.8. Establishing criteria for level of care and type of transportation to be used in pre-hospital emergency care (i.e., advanced life support vs. basic life support, ground air, or specialty unit transportation).

- 4.2.1.5.9. Establishing criteria for selection of patient destination.
- 4.2.1.5.10. Establishing educational and performance standards for communication resource personnel.
- 4.2.1.5.11. Establishing operational standards for communication resource.
- 4.2.1.5.12. Conducting effective system audit and quality assurance. The Medical Director shall have access to all relevant EMS records needed to accomplish this task. These documents shall be considered quality assurance documents and shall be privileged and confidential information.
- 4.2.1.5.13. Insuring the availability of educational programs within the system and that they are consistent with accepted local medical practice.
- 4.2.1.5.14. May delegate portions of his/her duties to other qualified individuals.

4.3 Medical Direction (Online, Direct Medical Control)

- 4.3.1. The practice of on-line medical direction shall exist and be available within the EMS system, unless impossible due to distance or geographic considerations. All pre-hospital providers, above the certification level of EMT-B, shall be assigned to a specific on-line communication resource by a predetermined policy and this shall be included in the application for ALS licensure.
- 4.3.2. When EMS personnel are transporting patients to locations outside of their geographic medical control area, they may utilize recognized communication resources outside of their own area.
- 4.3.3. Specific local protocols shall exist which define those circumstances under which on-line medical direction is required.
- 4.3.4. On-line medical direction is the practice of medicine and all orders to which the pre-hospital provider shall originate from/or be under the direct supervision and responsibility of a physician.
- 4.3.5. The receiving hospital shall be notified prior to the arrival of each patient transported by the EMS system unless directed otherwise by local protocol.
- 4.3.6. On-Line Medical Director
 - 4.3.6.1. This physician shall be approved to serve in this capacity by system (Off-Line) Medical Director.
 - 4.3.6.2. This physician shall have received education to the level of proficiency approved by the off-line Medical Director for proper provision of on-line medical direction, including communications equipment, operation and techniques.
 - 4.3.6.3. This physician shall be appropriately trained in pre-hospital protocols, familiar with the capabilities of the pre-hospital providers, as well as local EMS operational policies and regional critical care referral protocols.
 - 4.3.6.4. This physician shall have demonstrated knowledge and expertise in the pre-hospital care of critically ill and injured patients.
 - 4.3.6.5. This physician assumes responsibility for appropriate actions of the pre-hospital provider to the extent that the on-line physician is involved in patient care

direction.

- 4.3.6.6. The on-line physician is responsible to the system Medical Director (off-line) regarding proper implementation of medical and system protocols.

4.4 Authority for Control of Medical Services at the Scene of Medical Emergency.

- 4.4.1. Authority for patient management in a medical emergency shall be the responsibility of the individual in attendance who is most appropriately trained and knowledgeable in providing pre-hospital emergency stabilization and transport.
- 4.4.2. When an advanced life support (ALS) squad, under medical direction, is requested and dispatched to the scene of an emergency, a doctor/patient relationship has been established between the patient and the physician providing medical direction.
- 4.4.3. The pre-hospital provider is responsible for the management of the patient and acts as the agent of medical direction.
- 4.4.4. Authority for Scene Management.
Authority for the management of the scene of a medical emergency shall be vested in appropriate public safety agencies. The scene of a medical emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition, and priority shall be placed upon the interests of those persons exposed to the more serious risks to life and health. Public safety personnel shall ordinarily consult emergency medical services personnel or other authoritative medical professionals at the scene in the determination of relevant risks.

4.5 Patient's Private Physician Present

The EMT should defer to the orders of the private physician. The base station should be contacted for record keeping purposes if on-line medical direction exists. The ALS squad's responsibility reverts back to medical direction or on-line medical direction at any time when the physician is no longer in attendance.

4.6 Intervener Physician Present and Non-Existent On-Line Medical Direction

- 4.6.1. When the intervener physician has satisfactorily identified himself as a licensed physician and has expressed his willingness to assume responsibility and document his intervention in a manner acceptable to the local emergency medical services system (EMSS); the pre-hospital provider should defer to the orders of the physician on the scene if they do not conflict with system protocol.
- 4.6.2. If treatment by the intervener physicians at the emergency scene differs from that outlined in a local protocol, the physician shall agree in advance to assume responsibility for care, including accompanying the patient to the hospital. In the event of a mass casualty incident or disaster, patient needs may require the intervener physician to remain at the scene.

4.7 Intervener Physician Present and Existent On-Line Medical Direction

- 4.7.1. If an intervener physician is present and on-line medical direction does exist the on-line physician should be contacted and the on-line physician is ultimately responsible.
- 4.7.2. The on-line physician has the option of managing the case entirely, working with the intervener physician, or allowing him to assume responsibility.
- 4.7.3. If there is any disagreement between the intervener physician and the on-line physician, the pre-hospital provider should take orders from the on-line physician and place the intervener physician in contact with on-line physician.
- 4.7.4. In the event the intervener physician assumes responsibility, all orders to the pre-hospital provider shall be repeated to the communication resource for purposes of record-keeping.
- 4.7.5. The intervener physician should document his intervention in a manner acceptable to the local EMS system.
- 4.7.6. The decision of the intervener physician to accompany the patient to the hospital should be made in consultation with the on-line physician. Nothing in this section implies that the pre-hospital provider CAN be required to deviate from system protocols.

4.8 Communication Resource

A communication resource is an entity responsible for implementation of direct (on-line) medical control. This entity/facility shall be designated to participate in the EMS system according to a plan developed by the licensed ALS provider and approved by the system (off-line) medical director and the State Department of Health, DEMS.

- 4.8.1. The communication resource shall assure adequate staffing for the communication equipment at all times by health care personnel who have achieved a minimal level of competence and skill and are approved by the system medical director.
- 4.8.2. The communication resource shall assure that all requests for medical guidance assistance or advice by pre-hospital personnel will be promptly accommodated with an attitude of utmost participation, responsibility and cooperation.
- 4.8.3. The communication resource shall provide assurance that they will cooperate with the EMS system in collecting and analyzing data necessary to evaluate the pre-hospital care program as long as patient confidentiality is not violated.
- 4.8.4. The communication resource will consider the pre-hospital provider to be the agent of the on-line physician when they are in communication, regardless of any other employee/employer relationship.
- 4.8.5. The communication resource shall assure that the on-line physicians will issue transportation instructions and hospital assignments based on system protocols and objective analysis of patient's needs and facility capability and proximity.

- 4.8.6. No effort will be made to obtain institutional or commercial advantages through use of such transportation instructions and hospital assignments.
- 4.8.7. When the communication resource is acting as an agent for another hospital, the information regarding patient treatment and expected time of arrival will be relayed to the receiving hospital in an accurate and timely fashion.
- 4.8.8. Communication resource shall participate in regular case conferences involving the on-line physicians and pre-hospital personnel for purposes of problem identification and provide continuing education to correct any identified problems.
- 4.8.9. If the communication resource is located within a hospital facility, the hospital shall meet the requirements listed herein and the equipment used for on-line medical direction shall be located within the emergency department.

4.9 Educational Responsibilities

- 4.9.1. Because the on-line and off-line medical directors allow the use of their medical licenses, specific educational requirements should be established. This is not only to insure the best available care, but also to minimize liability. All personnel brought into the system must meet minimum criteria established by state law for each level; however, the law should in no way preclude a medical director from enforcing standards beyond this minimum.
- 4.9.2. Personnel may come to the system untrained (in which case the medical director will design and implement the educational program directly or through the use of ancillary instructors), or they may have previous training and/or experience. Although the Department of Transportation has defined curricula for training, the curricula are not standardized nationally, and often are not standardized within a state or county. Certification or licensure in one locale does not automatically empower an individual to function as an EMT within another system. The medical director must evaluate applicants trained outside the system in order to determine their level of competence. Such evaluation may be made in the form of written examinations, but should also include practical skills and a field internship with competent peers and time spent with the medical director.
- 4.9.3. The educational responsibilities of the medical director do not end with initial training; skills maintenance must be considered. To insure the knowledge does not stagnate, programs should cover all aspects of the initial training curriculum on a cyclical basis. Continuing education should comprise multiple formats, including lectures, discussions and case presentations, as well as practical situations that allow the EMT to be evaluated in action. The continuing education curriculum should also include topics suggested by audits, and should be utilized to introduce new equipment or skills.

4.10 Review and Audit

- 4.10.1. Personnel may be trained to the highest standards and many protocols may be written, but

if critical review is not performed, the level of patient care will deteriorate. Review is intended to determine inadequacies of the training program and inconsistencies in the protocols. The data base required includes pre-hospital care data, emergency department and inpatient (summary) data, and autopsy findings as appropriate. The cooperation of system administrators, hospital administrators, and local or state medical societies must be elicited. On occasion, the state legislature may be required to provide access to vital information.

4.10.2. The medical director or a designated person should audit pre-hospital run records, either randomly or inclusively. The data must be specifically evaluated for accuracy of charting and assessment; appropriateness of treatment; patterns of error, morbidity, and mortality; and need for protocol revision.

4.10.3. It cannot be assumed that all pre-hospital care will be supervised by on-line physicians. When proper or improper care is revealed by the audit process, prompt and appropriate praise or censorship should be provided by the medical director after consultation with the system administrator.

4.10.4. **Individual Case Review.**

4.10.4.1. Compliance with system rules and regulations is most commonly addressed by state and regional EMS offices. Audit by individual case review requires a more detailed plan. Each of the components defined in detail by the individual EMS system must be agreed on prior to the institution of any case review procedures. Case review may involve medical audit, including reviews of morbidity and mortality data (outcome-oriented review), and system audit, including compliance with rules and regulations as well as adherence to protocols and standing orders (process-oriented review). The personnel to be involved in a given case review process should include the off-line medical director; emergency department and critical care nurses; and EMS, technical and other support personnel who were involved in the specific cases.

4.10.4.2. The following must be written and agreed to in advance:

1. Procedural guidelines of how the individuals will interact during meetings.
2. Because considerations of medical malpractice may be present when issues concerning appropriateness of care and compliance with guidelines are raised, legal advice for procedural guidelines must be obtained prior to the institution of any medical audit program in order that medical malpractice litigation will neither result from nor become the subject of the meeting.
3. Confidentiality of case review in terms of local open meeting laws and public access to medical records and their distribution.
4. Format for recording the meeting and its outcome.
5. Access to overall system performance records, both current and historical, to allow comparison.

4.10.4.3. Overall outcome data (morbidity and mortality) and individual, unit-specific, and system-wide performance can be measured by the following means:

- A. The severity of presentation of patients must be known, and a scale for that measurement must be agreed on, included in all EMT education, and

- periodically checked for reliability.
- B. Appropriate treatment on scene and in transit should be recorded and subsequently evaluated for its effect on overall patient outcome.
 - C. At the emergency department, the severity of cases presenting (according to a severity scoring technique) and treatment needed should be recorded in detail.
 - D. An emergency department diagnosis and outcome in terms of admission to a general medical bed, critical care unit, or morgue must be known. The length of stay in the hospital, cost of stay, discharge status, and pathologic diagnosis should be made available.

PROPOSED

Section V



Medical First Responder

Section 41-59-3, MAC

First Responder - means a person who uses a limited amount of equipment to perform the initial assessment of and intervention with sick, wounded or otherwise incapacitated persons, who (i) is trained to assist other EMS personnel by successfully completing, within the previous two (2) years, an approved “First Responder: National Standard Curriculum” training program, as developed and promulgated by the United States Department of Transportation, (ii) is nationally registered as a First Responder by the National Registry of Emergency Medical Technicians; and (iii) is certified as a First Responder by the Mississippi State Department of Health, Division of Emergency Medical Services.

5.1 Training Authority Medical First Responder

The guidelines and minimum standards are set forth in order to establish a minimum level of training for the medical First Responder in the State of Mississippi. These guidelines and minimum standards shall be met by all medical First Responder courses in the state. Additionally, organized EMS districts as recognized by DEMS, Mississippi State Department of Health, are authorized to provide this training. DEMS may approve medical First Responder programs if it is determined after review by the DEMS staff and the Medical Direction, Training and Quality Assurance Committee that the objectives of the training program equal or exceed those of the State of Mississippi. All medical First Responder training programs must have DEMS approval prior to the start of class.

5.2 Medical First Responder Curriculum

Medical First Responder curriculum must conform, at minimum, to the National Standard Training Curriculum (NSTC) developed by the United States Department of Transportation and all current revisions as approved for use by DEMS. Minimum hours required for medical First Responder are: 40 didactic/lab. In addition, the following modules will be taken from the EMT Basic National Standard Training Curriculum (NSTC) developed by the United States Department of Transportation and all current revisions: Automatic External Defibrillator (AED), assist with the administration of an epinephrine auto-injector and oxygen therapy. Written permission from DEMS must be obtained prior to the start of a medical First Responder course.

5.3 Request for approval of medical First Responder training programs

A list of DEMS approved medical First Responder training programs will be available at the DEMS office and DEMS website. Request for approval of medical First Responder training programs not contained on the approved list shall be sent to DEMS with evidence and verification that:

- (A) The medical First Responder training program meets, at minimum, the requirements of the medical First Responder curriculum as given in this Section.
- (B) There are medical First Responder instructor certification and re-certification requirements, including an evaluation of instructor terminal competencies, provided in the requested training program.

Note: Credentialed EMS instructors of DEMS as trained through the MS EMS Instructor training program and in good standing, are considered as meeting the above requirement.

Approval must be given by the Medical Direction, Training and Quality Assurance Committee (MDTQA) and DEMS, prior to the start of any classes utilizing the proposed medical First Responder training program.

5.4 Medical First Responder Training Programs

MS medical First Responder training shall also include the instructor lesson plan for Basic EMT National Standard Training Curriculum (NSTC), Automatic External Defibrillation (AED) Section, assist with the administration of epinephrine auto-injector, and oxygen therapy. Additionally, it should be noted that current AHA Standards and Guidelines for CPR and AED will supersede NSTC.

1. The length of the medical First Responder CPR and AED course shall not be less than 8 hours (didactic and practical).
2. The complete MS medical First Responder educational program should be designed to provide the knowledge that will allow the student to arrive at decisions based on accepted medical knowledge and that will permit the professional growth of the medical First Responder.
3. The program should consist of at minimum two components: didactic instruction and clinical instruction, with optional supervised field experience in a system which functions under a medical command authority. The time required to complete each component may vary, in part being dependent upon the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.
4. The program should maintain on file for each component of the curriculum a reasonable comprehensive list of the terminal performance objectives to be achieved by the student. These objectives should delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.
5. The student should be informed about the methods and data used in determining grades and about the mechanism for appeal. Conditions governing dismissal from the program should be clearly defined in writing and distributed to the student at the beginning of the training program.
6. Evidence of student competence in achieving the educational objectives of the program should be kept on file. Documentation should be in the form of both written and practical examinations.
7. Classroom, clinical, and optional field faculty should also prepare written evaluations on each student. Documentation should be maintained identifying the counseling given to individual students regarding their performance and the recommendations made to correct inadequate performance. Documentation on whether or not the student followed through on faculty recommendations should also be maintained. Instruction should be supported by performance assessments.
8. Faculty should be presented with the program's educational objectives for uses in preparation of lectures and clinical and field practice. The course coordinator should ensure that stated educational objectives are covered and should answer any questions from students or clarify information presented by a lecturer.
 - a. Didactic instruction:
Lectures, discussions, and demonstrations presented by physicians and others who are competent in the field.
 - b. Clinical and other settings:
Instruction and supervised practice of emergency medical skills. Practice should not be limited to the development of practical skills alone, but should include knowledge and techniques regarding patient evaluations, development of patient rapport, and care for and

understanding of the patient's illness. Documentation should be maintained for each student's performance in all of the various areas. A frequent performance evaluation is recommended.

c. Field Experience (optional):

The field internship is a period of supervised experience in a structured overall EMS system. It provides the student with a progression of increasing patient care responsibilities which proceed from observation to working as a member of a team. There should be a provision for physician evaluation of student progress in acquiring the desired skills to be developed through this experience. The medical First Responder should have telecommunication with medical command authority. The initial position of the student on the EMS care team should be that of observer. After progressing through record keeping and participation in actual patient care, the student should eventually function as the patient care leader. However, the student should not be placed in the position of being a necessary part of the patient care team. The team should be able to function without the necessary use of a student who may be present.

9. General courses and topics of study must be achievement oriented and shall provide students with:

a. The necessary knowledge, skills, and attitudes to perform accurately and reliably the functions and tasks stated and implied in the "Job Description" and "Functional Job Analysis" found in the DOT, NISTC Course Guide.

b. Comprehensive instruction which encompasses:

(i) Development of knowledge and clinical skills appropriate for this level of care

(a) Introduction to EMS Systems

(b) The well-being of the First Responder

(c) Legal and Ethical Issues

(d) The Human Body

(e) Lifting and Moving Patients

(f) Airway management procedures

(g) Patient assessment including both a primary and secondary survey

(h) Managing patient circulation

(i) Identify and manage illness and injury

(j) Childbirth

(k) Assessment and management of common medical and trauma situations of infants/children

NOTE: The following curriculum must be taught in addition to that listed above.

Medical First Responder -

EMT-Basic NSC Module 2-1 Airway (for oxygen therapy)

EMT-Basic NSC Module 4-3 Cardiovascular Emergencies (for Automatic External Defibrillation)

EMT-Basic NSC Module 4-5 Allergies)for assisting with administration of epinephrine auto-injector

Medical First Responder training must include the following objectives from the EMT-Basic National Standard Curriculum:

The following objectives should be added to the First Responder Module 2 on Airway from the EMT-Basic NSC Module 2 to provide oxygen therapy training to medical First Responders.

Cognitive Objectives

- 2-1.2 List the signs of adequate breathing
- 2-1.10 Describe the steps in performing the skill of artificially ventilating a patient with bag-valve-mask while using the jaw thrust
- 2-1.11 List the parts of a bag-valve-mask system
- 2-1.12 Describe the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask for one and two rescuers
- 2-1.13 Describe the signs of adequate artificial ventilation using the bag-valve-mask
- 2-1.14 Describe the signs of inadequate artificial ventilation using the bag-valve-mask
- 2-1.15 Describe the steps in artificially ventilating a patient with a flow restricted, oxygen-powered ventilation device
- 2-1.16 List the steps in performing the actions taken when providing mouth-to-mouth and mouth-to-stoma artificial ventilation
- 2-1.19 Define the components of an oxygen delivery system
- 2-1.20 Identify a nonrebreather face mask and state the oxygen flow requirements needed for its use
- 2-1.21 Describe the indications for using a nasal cannula versus a nonrebreather face mask
- 2-1.22 Identify a nasal cannula and state the flow requirements needed for its use

Affective Objectives

- 2-1.24 Explain the rationale for providing adequate oxygenation through high inspired oxygen concentrations to patients who, in the past, may have received low concentrations.

Psychomotor Objectives

- 2-1.30 Demonstrate the assembly of a bag-valve-mask unit
- 2-1.31 Demonstrate the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask for one and two rescuers
- 2-1.32 Demonstrate the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask while using the jaw thrust
- 2-1.33 Demonstrate artificial ventilation of a patient with a flow restricted, oxygen-powered ventilation device
- 2-1.37 Demonstrate the correct operation of oxygen tanks and regulators
- 2-1.38 Demonstrate the use of a nonrebreather face mask and state the oxygen flow requirements needed for its use
- 2-1.39 Demonstrate the use of a nasal cannula and state the flow requirements needed for its use
- 2-1.40 Demonstrate how to artificially ventilate the infant and child patient
- 2-1.41 Demonstrate oxygen administration for the infant and child patient

The following objectives should be added to the First Responder Training Program

from the EMT-Basic NSC Module 4 to provide training for assisting with the administration of epinephrine auto-injectors to medical First Responders.

Cognitive Objectives

At the completion of this lesson, the medical First Responder student will be able to:

- 4-5.1 Recognize the patient experiencing an allergic reaction
- 4-5.2 Describe the emergency medical care of the patient with an allergic reaction.
- 4-5.3 Establish the relationship between the patient with an allergic reaction and airway management
- 4-5.4 Describe the mechanisms of allergic response and the implications for airway management
- 4-5.5 State the generic and trade names, medication forms, dose, administration, action, and contraindications for the epinephrine auto-injector
- 4-5.6 Evaluate the need for medical direction in the emergency medical care of the patient with an allergic reaction
- 4-5.7 Differentiate between the general category of those patients having an allergic reaction and those patients having an allergic reaction and requiring immediate medical care, including immediate use of epinephrine auto-injector

Affective Objectives

- 4-5.8 Explain the rationale for administering epinephrine using an auto-injector

Psychomotor Objectives

- 4-5.9 Demonstrate the emergency medical care of the patient experiencing an allergic reaction
- 4-5.10 Demonstrate the use of epinephrine auto-injector
- 4-5.11 Demonstrate the assessment and documentation of patient response to an epinephrine injection
- 4-5.12 Demonstrate proper disposal of equipment
- 4-5.13 Demonstrate completing a pre-hospital care report for patients with allergic emergencies

The following objectives should be added to the First Responder Training Program from the EMT-Basic NSC Module 4 and/or nationally AHA guidelines to provide training for cardiovascular emergencies and the use of automated external defibrillators to medical First Responders.

Cognitive Objectives

- 4-3.1 Describe the structure and function of the cardiovascular system
- 4-3.2 Describe the emergency medical care of the patient experiencing chest pain/discomfort
- 4-3.3 List the indications for automated external defibrillation
- 4-3.4 List the contraindications for automated external defibrillation
- 4-3.5 Define the role medical First Responder in the emergency cardiac care system
- 4-3.6 Explain the impact of age and weight on defibrillation
- 4-3.7 Discuss the position of comfort for patients with various cardiac emergencies
- 4-3.8 Establish the relationship between airway management and the patient with cardiovascular compromise
- 4-3.9 Predict the relationship between the patient experiencing cardiovascular

- compromise and basic life support
- 4-3.10 Discuss the fundamentals of early defibrillation
 - 4-3.11 Explain the rationale for early defibrillation
 - 4-3.12 Explain that not all chest pain patients result in cardiac arrest and do not need to be attached to an automated external defibrillator
 - 4-3.13 Explain the importance of pre-hospital ACLS intervention if it is available
 - 4-3.14 Explain the importance of urgent transport to a facility with Advanced Cardiac Life Support if it is not available in the pre-hospital setting
 - 4-3.15 Discuss the various types of automated external defibrillators
 - 4-3.16 Differentiate between the fully automated and the semi-automated defibrillator
 - 4-3.17 Discuss the procedures that must be taken into consideration for standard operations of the various types of automated external defibrillators
 - 4-3.18 State the reasons for assuring that the patient is pulseless and apneic when using the automated external defibrillator
 - 4-3.19 Discuss the circumstances which may result in inappropriate shocks
 - 4-3.20 Explain the considerations for interruption of CPR, when using the automated external defibrillator
 - 4-3.21 Discuss the advantages and disadvantages of automated external defibrillators
 - 4-3.22 Summarize the speed of operation of automated external defibrillation
 - 4-3.23 Discuss the use of remote defibrillation through adhesive pads
 - 4-3.24 Discuss the special considerations for rhythm monitoring
 - 4-3.25 List the steps in the operation of the automated external defibrillator
 - 4-3.26 Discuss the standard of care that should be used to provide care to a patient with persistent ventricular fibrillation and no available ACLS
 - 4-3.27 Discuss the standard of care that should be used to provide care to a patient with recurrent ventricular fibrillation and no available ACLS
 - 4-3.28 Differentiate between the single rescuer and multi-rescuer care with an automated external defibrillator
 - 4-3.29 Explain the reason for pulses not being checked between shocks with an automated external defibrillator
 - 4-3.30 Discuss the importance of coordinating ACLS trained providers with personnel using automated external defibrillators
 - 4-3.31 Discuss the importance of post-resuscitation care
 - 4-3.32 List the components of post-resuscitation care
 - 4-3.33 Explain the importance of frequent practice with the automated external defibrillator
 - 4-3.34 Discuss the need to complete the Automated Defibrillator: Operator's Shift Checklist
 - 4-3.35 Discuss the role of the American Heart Association (AHA) in the use of automated external defibrillation
 - 4-3.36 Explain the role medical direction plays in the use of automated external defibrillation
 - 4-3.37 State the reasons why a case review should be completed following the use of the automated external defibrillator
 - 4-3.38 Discuss the components that should be included in a case review
 - 4-3.39 Discuss the goal of quality improvement in automated external defibrillation
 - 4-3.40 Recognize the need for medical direction of protocols to assist in the emergency medical care of the patient with chest pain
 - 4-3.43 Define the function of all controls on an automated external defibrillator, and

describe event documentation and battery defibrillator maintenance

Affective Objectives

4-3.44 Defend the reasons for obtaining initial training in automated external defibrillation and the importance of continuing education

4-3.45 Defend the reason for maintenance of automated external defibrillators

Psychomotor Objectives

4-3.47 Demonstrate the assessment and emergency medical care of a patient experiencing chest pain/discomfort

4-3.48 Demonstrate the application and operation of the automated external defibrillator

4-3.49 Demonstrate the maintenance of an automated external defibrillator

4-3.50 Demonstrate the assessment and documentation of patient response to the automated external defibrillator

4-3.51 Demonstrate the skills necessary to complete the Automated Defibrillator: Operator's Shift Checklist

4-3.54 Practice completing a pre-hospital care report for patients with cardiac emergencies

10. Operational Policies

1. Student matriculation practices and student and faculty recruitment should be non-discriminatory with respect to race, color, creed, sex, or national origin. Student matriculation and student and faculty recruitment practices are to be consistent with all laws regarding non-discrimination. It is recommended that records be kept for a reasonable period of time on the number of students who apply and the number accepted, as well as a placement history of those who complete the program.

- * Announcements and advertising about the program shall reflect accurately the training being offered.

- * The program shall be educational and students shall use their scheduled time for educational experiences.

- * Health and safety of students, faculty, and patients shall be adequately safeguarded.

- * Costs to the student shall be reasonable and accurately stated and published.

- * Policies and process for student withdrawal and refunds on tuition and fees shall be fair, and made known to all applicants.

B. Curriculum Description

Instructional content of the educational program should include the successful completion of stated educational objectives that fulfill local and regional needs and that satisfy the requirements of this curriculum section. The curriculum should be organized to provide the student with knowledge required to understand fully the skills that are taught in this program. It is important not to lose sight of the original purpose of the medical First Responder level. The curriculum includes only the portions of the NSTC for the EMT-Basic which are relevant for this level of care. Students should have an opportunity to acquire clinical experience and practice skills related to the emergency

medical care of these patients. Students should also understand the ethical and legal responsibilities they assume as students and are being prepared to assume as graduates.

5.5 Medical First Responder classes, class approval

The DEMS may approve medical First Responder training classes if it is determined, after review of medical First Responder class request forms, that the objectives of the class equal or exceed those of the State of Mississippi.

Medical First Responder class approval forms can be requested from DEMS or be completed on the DEMS website. Credentialed medical First Responder instructors should complete the class approval form and submit to DEMS, at minimum, fourteen calendar days prior to the first day of class. DEMS will assign a class number to all approved requests and return to the credentialed medical First Responder instructor. Incomplete paperwork will be returned without action.

5.6 Medical First Responder classes, initial roster

Initial rosters shall be completed by the credentialed medical First Responder instructor immediately following the second meeting of the class. Initial roster forms can be obtained from DEMS or be completed on the DEMS website. A final roster for a full or refresher First Responder class will not be accepted without an initial roster on file with DEMS.

5.7 Medical First Responder classes, final roster

Final rosters shall be completed by the credentialed medical First Responder instructor immediately following the end of a full First Responder or First Responder refresher class. The final roster shall be inclusive of all students on the initial roster. The final roster will note students who withdrew, failed and completed the medical First Responder class. The final roster form can be obtained from DEMS or be completed on the DEMS website. Students successfully completing the class will not be allowed to test National Registry until a final roster is on file with DEMS. Credentialed medical First Responder instructors must complete the final roster affidavit regarding First Responder DOT practical skill completion as well as automatic external defibrillator (AED), assisting with the administration of epinephrine by auto-injector, and oxygen therapy didactic and practicals.

5.8 Medical First Responder Training Programs, Minimum Admittance Criteria

1. Must be sixteen (16) years of age prior to class completion.

5.9 Medical First Responder Refresher Training

The Mississippi medical First Responder Refresher curriculum must conform, at minimum, to the National Standard Training Curriculum (NSTC) developed by the United States Department of Transportation and all current revisions as approved for use by DEMS. Minimum hours required for medical First Responder refresher training are: 12 hours didactic/lab. In addition, the following modules will be refreshed as taken from the EMT Basic Refresher National Standard Training Curriculum (NSTC) developed by the United States Department of Transportation and all current revisions: Automatic External Defibrillator (AED), assist with the administration of an epinephrine auto-injector and oxygen therapy. Written permission from DEMS must be obtained prior to the start of a medical First Responder refresher course. Medical First Responder refresher training must be accomplished by all certified Mississippi medical First Responders during their National

Registry certification period.

NOTE: First Responder Refresher Course Instructors should refer to:
Section 5.3 for request for approval of medical First Responder training programs
Section 5.5 for Medical First Responder classes, class approval
Section 5.6 for Medical First Responder classes, initial roster
Section 5.7 for Medical First Responder classes, final roster

DEMS, on receipt of a properly approved class request, initial roster, and final roster will prepare certificates of completion for refresher training for all persons on the final roster and return them to the instructor.

5.10 Prerequisites to certification as a medical First Responder (training obtained in Mississippi)

1. Age of at least 16 years.
2. Completion of the Board's approved medical First Responder Training Program (Note: This includes passage of the National Registry examination).
3. Verification of Medical Control (Jurisdictional Medical Control Agreement) See Appendix 7.

5.11 Prerequisites to certification as a medical First Responder (training obtained in another state)

1. Age of at least 16 years.
2. Completion of a medical First Responder program which meets the guidelines of the First Responder national standard curriculum. Written verification from state of training and of current status.
3. Completion of a state-approved medical First Responder skills course which must include automatic external defibrillation, DOT EMT-Basic module for assisting with the administration of epinephrine by auto-injector and DOT EMT-Basic module for oxygen therapy. (or equivalent with MSDH, DEMS approved terminal competencies).
4. Applicant must be registered as a medical First Responder by the National Registry of EMTs. This is documented by submitting a copy of the National Registry wallet card.
5. Verification of Medical Control (Jurisdictional Medical Control Agreement) See Appendix 7.

NOTE: The Mississippi DEMS maintains the right to refuse reciprocity to any nationally registered medical First Responder if the submitted curriculum does not meet the guidelines of the national standard curriculum and those required by the State of Mississippi.

5.12 Medical First Responder Certification

1. Any person desiring certification as a medical First Responder shall apply to the DEMS using forms provided (Application for State Certification).
2. All certification applications must be accompanied by a ten dollar (\$10.00) money order or business check payable to the Mississippi State Department of Health - DEMS, a copy of applicant's National Registry card, and a Jurisdictional Medical Control Agreement from a DEMS approved "system" medical director.

3. DEMS may withhold or deny the application for certification for a like period of time equal to the like period of time under which a person failed to comply. Mississippi requires that all medical First Responder's maintain current registration with the National Registry of Emergency Medical Technicians.

5.13 Medical First Responder, grounds for suspension or revocation

1. Fraud or any mis-statement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.
2. Gross negligence.
3. Repeated negligent acts.
4. Incompetence.
5. Disturbing the peace while on duty.
6. Recklessly disregarding the speed regulations prescribed by law while on duty.
7. Failure to carry the Mississippi State Department of Health issued certification card while on duty or failure to wear appropriate identification as approved by State Department of Health, Division of EMS.
8. Failure to maintain current registration by the National Registry of EMTs.
9. Failure to maintain all current training standards as required by the State Department of Health.
10. The commission of any fraudulent dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.
11. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction.
12. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the State Department of Health, DEMS, pertaining to pre-hospital personnel.
13. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.
14. Addiction to, excessive use of, or misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.
15. Functioning outside the supervision of medical control in the field care system.
16. Permitting, aiding or abetting an unlicensed or uncertified person to perform activities requiring a license or certification.

5.14 Recertification of medical First Responders

1. Any person desiring re-certification as a medical First Responder shall apply to DEMS using forms provided (Application for state certification)
2. All re-certification applications must be accompanied by ten dollar (\$10.00) money order or business check payable to the Mississippi State Department of Health - DEMS. Also include copy of current National Registry card and current Jurisdictional Medical Control Agreement. See Appendix 7.
3. All medical First Responder's failing to re-certify with DEMS on or before the expiration date of his/her certification period will be considered officially expired.
4. DEMS may withhold or deny an application for re-certification for a like period of time equal to the like period of time under which a person fails to comply.
5. A medical First Responder certificate issued shall be valid for a period not exceeding two (2) years from date of issuance and may be renewed upon payment of a renewal

fee of ten dollars (\$10.00), which shall be paid to the Board provided that the holder meets the qualifications set forth in regulations promulgated by the Board.

6. The Board may suspend or revoke a certificate so issued at any time it is determined that the holder no longer meets the prescribed qualifications.

5.15 Description of the Occupation and Competency of the medical First Responder

Job Summary

A Mississippi medical First Responder activates the EMS system, surveys the scene for hazards, contains those hazards, gains access to the injured or sick, gathers relevant patient data, provides immediate emergency medical care using a limited amount of equipment, controls the scene, and prepares for the arrival of the ambulance. It must also be stressed that ongoing medical control and evaluation of the functioning medical First Responder is essential to the maintenance of medical care quality. As with all professionals in the medical community, it must be realized that continuing education is an integral part of the medical First Responders ability to maintain a high degree of competency.

Functional Job Analysis

Mississippi medical First Responder Characteristics

The Mississippi medical First Responder must be a person who can remain calm while working in difficult and stressful circumstances, as well as one who is capable of combining technical skills, theoretical knowledge, and good judgment to insure optimal level of fundamental emergency care to sick or injured patients while adhering to specific guidelines within the given scope of practice.

The Mississippi medical First Responder is expected to be able to work alone, but must also be a team player. Personal qualities such as the ability to “take charge” and control the situation are essential, as are the maintaining of a caring and professional attitude, controlling one’s own fears, presenting a professional appearance, staying physically fit, and keeping one’s skills and abilities up to date. The Mississippi medical First Responder must be willing to adhere to the established ongoing medical control and evaluation required for the maintenance of quality medical care.

Self-confidence, a desire to work with people, emotional stability, tolerance for high stress, honesty, a pleasant demeanor, and the ability to meet the physical and intellectual requirements demanded by this position are characteristics of the competent First Responders. The Mississippi medical First Responder also must be able to deal with adverse social situations which include responding to calls in districts known to have high crime rates. The Mississippi medical First Responder ideally possesses an interest in working for the good of society and has a commitment to doing so.

Physical Demands

Aptitudes required for work of this nature are good physical stamina, endurance, and body condition that would not be adversely affected by having to walk, stand, lift, carry, and balance at times, in excess of 125 pounds. Motor coordination is necessary because over uneven terrain, the patient’s and the First Responder’s well being, as well as other workers’ well being must not be jeopardized.

Other

Use of telephone or radio dispatch for coordination of prompt emergency services is

essential. Accurately discerning street names through map reading, and correctly distinguishing house numbers or business addresses are essential to task completion in the most expedient manner. Concisely and accurately describing orally to dispatcher and other concerned staff, one's impression of patient's condition, is critical as the First Responder works in emergency conditions where there may not be time for deliberation. The Mississippi medical First Responder must also be able to accurately report all relevant patient data, which is generally, but not always, outlined on a prescribed form. Verbal and reasoning skills are used extensively. The ability to perform mathematical tasks is minimal, however, it does play a part in activities such as taking vital signs, making estimates of time, calculating the number of persons at a scene, and counting the number of persons requiring specific care.

Note: A more detailed Functional Job Analysis can be found in Appendix A of the First Responder National Standard Curriculum

5.16 Performance Standards for medical First Responder

The Mississippi medical First Responder who functions within the State of Mississippi must be able to demonstrate the following skills and understand the elements of total emergency care to the satisfaction of the local training coordinator and the certifying agency. Training programs must be approved by the Mississippi State Department of Health, DEMS and/or the Department of Education.

The medical First Responder's primary responsibility is to the patient and should include both an oral exam and an appropriate physical exam. Scene size-up including: scene safety, mechanism of injury, number of patients, additional help and consideration of cervical stabilization.

The skills listed herein will enable the medical First Responder to carry out all First Responder level patient assessment and emergency care procedures.

1. Given a possible infectious exposure, the First Responder will use appropriate personal protective equipment. At the completion of care, the First Responder will properly remove and discard the protective garments.
2. Given a possible infectious exposure, the First Responder will complete disinfection/cleaning and all reporting documentation.
3. Demonstrate an emergency move.
4. Demonstrate a non-emergency move.
5. Demonstrate the use of equipment utilized to move patient's in the pre-hospital arena.
6. Demonstrate competence in psychomotor objectives for:
 1. EMS Systems
 2. Well-Being of the First Responder
 3. Legal and Ethical Issues
 4. The Human Body
 5. Lifting and Moving Patients
7. Demonstrate the steps in the head-tilt chin lift.
8. Demonstrate the steps in the jaw thrust.
9. Demonstrate the techniques of suctioning.
10. Demonstrate the steps in mouth-to-mouth ventilation with body substance isolation.
11. Demonstrate how to use a resuscitation mask to ventilate a patient.
12. Demonstrate how to ventilate a patient with a stoma.
13. Demonstrate how to measure and insert an oropharyngeal and nasopharyngeal

- airway.
14. Demonstrate how to ventilate infant and child patients.
 15. Demonstrate how to clear a foreign body airway obstruction in a responsive child and adult.
 16. Demonstrate how to clear a foreign body airway obstruction in a responsive and unresponsive
 1. Infant
 2. Child
 3. Adult
 17. Demonstrate the assembly of a bag-valve-mask unit.
 18. Demonstrate the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask for one and two rescuers.
 19. Demonstrate the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask while using the jaw thrust.
 20. Demonstrate artificial ventilation of a patient with a flow restricted, oxygen-powered ventilation device.
 21. Demonstrate the correct operation of oxygen tanks and regulators.
 22. Demonstrate the use of a nonrebreather face mask and state the oxygen flow requirements needed for its use.
 23. Demonstrate the use of a nasal cannula and state the flow requirements needed for its use.
 24. Demonstrate how to artificially ventilate the infant and child patient.
 25. Demonstrate oxygen administration for the infant and child patient.
 26. Demonstrate the ability to differentiate various scenarios and identify potential hazards.
 27. Demonstrate the techniques for assessing
 1. Mental status
 2. The airway
 3. If the patient is breathing
 4. If the patient has a pulse
 5. External bleeding
 6. Patient skin color, temperature, condition, and capillary refill (infants and children only)
 28. Demonstrate questioning a patient to obtain SAMPLE history.
 29. Demonstrate the skills involved in performing the physical exam.
 30. Demonstrate the on-going assessment.
 31. Demonstrate the proper technique of chest compression on
 1. Adult
 2. Child
 3. Infant
 32. Demonstrate the steps of CPR
 1. One rescuer adult CPR
 2. Two rescuer adult CPR
 3. Child CPR
 4. Infant CPR
 33. Demonstrate the assessment and emergency medical care of a patient experiencing chest pain/discomfort.
 34. Demonstrate the application and operation of the automated external defibrillator.
 35. Demonstrate the maintenance of an automated external defibrillator.
 36. Demonstrate the assessment and documentation of patient response to the automated

- external defibrillator.
37. Demonstrate the skills necessary to complete the Automated Defibrillator: Operator's Shift Checklist.
 38. Demonstrate proper documentation of a pre-hospital care report for patients with cardiac emergencies.
 39. Demonstrate the steps in providing emergency medical care to patient with
 1. A general medical complaint
 2. Altered mental status
 3. Seizures
 4. Exposure to cold
 5. Exposure to heat
 6. A behavioral change
 7. A psychological crisis
 40. Demonstrate the following methods of emergency medical care for external bleeding.
 1. Direct pressure
 2. Diffuse pressure
 3. Pressure points
 41. Demonstrate the care of the patient exhibiting signs and symptoms of internal bleeding.
 42. Demonstrate the steps in the emergency medical care of
 1. Open soft tissue injuries
 2. A patient with an open chest wound
 3. A patient with open abdominal wounds
 4. A patient with an impaled object
 5. A patient with an amputation
 6. An amputated part
 43. Demonstrate the emergency medical care of a patient with a painful, swollen, deformed extremity.
 44. Demonstrate opening the airway in a patient with suspected spinal cord injury.
 45. Demonstrate evaluating a responsive patient with a suspected spinal cord injury.
 46. Demonstrate stabilizing of the cervical spine.
 47. Demonstrate the steps to assist in the normal cephalic delivery.
 48. Demonstrate necessary care procedures of the fetus as the head appears.
 49. Attend to the steps in the delivery of the placenta.
 50. Demonstrate the post-delivery care of the mother.
 51. Demonstrate the care of the newborn.
 52. Demonstrate assessment of the infant and child.
 53. Perform triage of a mass casualty incident.
 54. Demonstrate the emergency medical care of the patient experiencing an allergic reaction.
 55. Demonstrate the use of epinephrine auto-injector.
 56. Demonstrate the assessment and documentation of patient response to an epinephrine injection.
 57. Demonstrate proper disposal of equipment.
 58. Demonstrate completing a pre-hospital care report for patients with allergic emergencies.
 59. Other knowledge and competencies may be added as revisions occur with the National Standard EMT Basic Curriculum.

Note: Skills and medications not listed in these regulations may not be performed by a

Mississippi medical First Responder until each skill and/or medication has been individually and specifically approved by DEMS in writing

5.17 Area and Scope of Practice of the medical First Responder

The Mississippi medical First Responder represents the first component of the emergency medical care system. Through proper training the medical First Responder will be able to provide basic life support to victims during emergencies, minimize discomfort and possible further injuries. The medical First Responder may provide non-invasive emergency procedures and services to the level described in the First Responder National Standard Training Curriculum. Those procedures include recognition, assessment, management, transportation and liaison.

A Mississippi medical First Responder is a person who has successfully completed an approved training program and is certified. The medical First Responder training program must equal or exceed the educational goals and objectives of the National Standard Training curriculum for the First Responder along with applicable modules for automatic external defibrillation, assisting with the administration of epinephrine by auto-injector, and oxygen therapy from the National Standard Training curriculum for EMT-Basic.

Description of Tasks

The Mississippi medical First Responder answers verbally to telephone or radio emergency calls from dispatcher to provide efficient and immediate care to critically ill and injured persons using a limited amount of equipment. Responds safely to the address or location as directed by radio dispatcher. Visually inspects and assesses or “sizes up” the scene upon arrival to determine if scene is safe, to determine the mechanism of illness or injury, and the total number of patients involved. Directly reports verbally to the responding EMS unit or communications center as to the nature and extent of injuries, the number of patients, and the condition of each patient, and identifies assessment findings which may require communication with medical direction for advice.

Assesses patient constantly while awaiting additional EMS resources, administers care as indicated. Requests additional help if necessary. Creates a safe traffic environment in the absence of law enforcement. Renders emergency care to adults, children and infants based on assessment findings, using a limited amount of equipment. Opens and maintains patient airway, ventilates patient, provides oxygen therapy, performs CPR, utilizes automated and semi-automated external defibrillators. Provides pre-hospital emergency care of simple and multiple system trauma such as controlling hemorrhage, bandaging wounds, manually stabilizing painful, swollen and deformed extremities. Provides emergency medical care to include assisting in childbirth, management of respiratory problems, altered mental status, and environmental emergencies, assisting with the administration of epinephrine by auto-injector.

Searches for medical identification as clue in providing emergency care. Reassures patients and bystanders while working in a confident and efficient manner, avoids misunderstandings and undue haste while working expeditiously to accomplish the task. Extricates patients from entrapment, assesses extent of injury, assists other EMS providers in rendering emergency care and protection to the entrapped patient. Performs emergency moves, assists other EMS providers in the use of prescribed techniques and appliances for safe removal of the patient.

Assists other EMS providers in lifting patient onto stretcher, placing patient in ambulance, and insuring that patient and stretcher are secured. Radios dispatcher for additional help or

special rescue and/or utility services. Reports verbally all observations and medical care of the patient to the transporting EMS unit, provides assistance to transporting staff. Performs basic triage where multiple patient needs exist. Restocks and replaces used supplies, uses appropriate disinfecting procedures to clean equipment, checks all equipment to insure adequate working condition for next response. Attends continuing education and refresher courses as required by employers, medical direction, and DEMS.

DRAFT